

THE MEDICAL PROFESSION IN A TRANSFORMING SOUTH AFRICAN SOCIETY: IDEALS, VALUES AND ROLE

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature:

Date: February 11, 2000

Executive Summary

Medicine in our country is under severe stress, brought about by internal and external forces that need a response from the medical profession. The profession's attempts and response will fall short unless the profession itself is aligned with the new social ethos and the responses are based on the profession's inherent values.

Problem Statement:

Medical doctors have always been highly valued in society because of the duty they have when illness and disease set in. As individuals, doctors have fulfilled other important roles in the communities where they work. These include giving advice to young people on career choices, counseling on various matters and provision of material help where there is need. This profession has for a long time been shrouded in mystery, being a trade learnt by a few. All these factors contributed to their social standing increasing phenomenally. There is a view that this has also led to public perceptions that doctors are the rich untouchable elite who have no interest or are unconcerned about problems faced by society. The medical profession faces a challenge that is more significant because of the value placed on it by society. The numerous submissions by the victims of human rights abuses to the Truth and Reconciliation Commission have cast a shadow of doubt on the medical profession for its complicity in these acts. The present government has declared transformation of health care as one of its top priorities. The response of the medical profession to this initiative has so far not led to any significant changes of public perception that the profession is unwilling to participate in the transformation of our society.

The challenge and subject of discussion in this thesis therefore is:

“What is the ideal role of the medical profession in a transforming South African society?”

The medical profession, being the nerve centre of health care, has a big responsibility in social transformation. Doctors stand accused as a collective for failing to protect the human rights of patients and not living up to the standards of ethics required of them when

patients' rights were violated. The Truth and Reconciliation Commission record of the hearings into the role of the professional organisations in health is used in this thesis to illustrate how serious society views the medical profession's role in the human rights abuses of the past.

Based on the T. R. C's report and the assumption that society traditionally places high value on the medical profession, I conducted a survey among South African doctors to test their attitudes towards a range of policy and transformational issues. The unit of analysis was the medical doctors who are in active practice in South Africa in whatever mode of practice. The survey sought to explore the awareness of the respondents about a range of transformation policy changes and invite their comments on the role that they envisage for the medical profession in the process of transformation of society. There is unfortunately scarcity or a lack of applicable South African literature on this topic thus limiting local material for referencing. The search of international literature only yielded the subject of the study of professional values and not necessarily the role of a medical profession in a transforming society.

The medical profession has to re-visit its foundations, analyse its history and map out its future in the context of the South African realities. It must find a way of aligning itself with the new ethos and diverse cultures South Africa possesses. Medicine has its own traditional goals and values derived and adapted from society's diverse cultural value systems. With its national and international networks, the inherent knowledge and skills that it possesses, guided by an ethical code, the Hippocratic Oath that serves as a public promise, it influences policy on the country's health care system - a mechanism that government uses to provide a basic human need.

The medical profession therefore has to be responsive to the needs of society as much as society needs to support the profession. This thesis explores the role that the profession should play in a transforming South African society. The argument is that this can only be done through the profession examining its values and aligning itself with broader societal value systems, the moral and social norms. It is further argued that visible realistic commitment by the profession to public health will lead to an improvement in its public image. It is the actions or non-actions of the majority that the public notices. The majority

of respondents to the survey have indicated that they approve of the transformation policies in health but that they may differ in the way they were introduced.

Executive Summary: (Afrikaans translation)

Die geneeskunde in ons land is onder geweldige druk as gevolg van interne en eksterne faktore en dit is nodig dat die mediese beroep reageer. Dit sal die beroep egter nie help om te reageer indien sy lede hulle nie met die nuwe maatskaplike etos vereenselwig nie en die reaksie op die inherente waardes van die mediese beroep geskoei word nie.

Probleemstelling

Mediese dokters is nog altyd baie hoog geag deur die gemeenskap as gevolg van die verpligting wat hulle het om na mense om te sien wanneer hulle siek word. In hulle individuele hoedanigheid het dokters ook ander belangrike bydraes tot hulle gemeenskappe gelewer. Dit sluit in: advies aan jong mense oor loopbaankeuses, berading en die verskaffing van finansiële hulp waar nodig. Die beroep as sulks was egter vir baie lank ietwat van 'n misterie omdat dit 'n vakrigting is waarin baie min mense hulle kon bekwaam. Al hierdie faktore het die maatskaplike aansien/waarde van dokters geweldig verhoog. Daar is ook diegene wat van mening is dat hierdie faktore aanleiding gegee het tot die openbare mening dat dokters 'n ryk en onaantasbare elite is en glad nie in die probleme van die gemeenskap belangstel nie. Die etlike voorleggings deur die slagoffers van menseregtevergrepe aan die Waarheids- en Versoeningskommissie het ook vrae rondom die beroep se betrokkenheid by sodanige gevalle laat ontstaan. Die huidige regering het die transformasie van gesondheidsorg as een van sy grootste prioriteite verklaar. Die reaksie van die beroep hierop het tot dusver nie tot enige noemenswaardige veranderinge in die openbare mening dat dokters nie bereid is om aan die transformasie van ons gemeenskap deel te neem gelei nie.

Die uitdaging en onderwerp van bespreking van hierdie tesis is dus:

Wat is die ideale rol van die mediese beroep in die transformasie van die Suid-Afrikaanse gemeenskap?

As die sentrum van gesondheidsorg het die mediese beroep 'n groot verantwoordelikheid in maatskaplike transformasie. Dokters word kollektief beskuldig dat hulle nagelaat het om die menseregte van pasiënte te beskerm en nie voldoen het aan die nodige etiese standaarde wat van hulle verwag word in die tyd toe pasienteregte geskend is nie. Die rekord van die verhore van die Waarheids- en Versoeningskommissie oor die rol van professionele gesondheidsorganisasies is vir die doeleindes van hierdie tesis gebruik om te illustreer hoe ernstig die gemeenskap voel oor die mediese beroep se rol in die menseregte vergrype van die verlede.

Gegronde op die WVK-verslag en die aanname dat die gemeenskap die mediese beroep hoog ag, het ek 'n meningsopname onder 300 Suid-Afrikaanse dokters gedoen om hulle houding teen 'n aantal beleids- en transformasiekwessies te toets. Die eenheid van analise was mediese dokters wat in die aktiewe praktyk staan, ongeag hulle praktykgebied. Die opname het gepoog om te bepaal wat die vlak van bewustheid by die respondente oor 'n aantal beleidsveranderinge gerig op transformasie is, en hulle uit te nooi om kommentaar te lewer op die rol wat hulle meen die mediese beroep behoort in die proses te speel. Ongelukkig is daar nie toepaslike Suid-Afrikaanse literatuur oor die onderwerp beskikbaar nie. 'n Internasionale literatuursoektog het net studies rondom waardes opgelewer, en nie oor die rol van 'n mediese beroep in die transformasie van 'n gemeenskap nie.

Die mediese beroep moet die grondslag van sy wese in oenskou neem, die geskiedenis analiseer en sy toekoms in die konteks van die Suid-Afrikaanse realiteite uitstippel. Die beroep moet 'n manier vind om homself met die nuwe etos en uiteenlopende kulture van Suid-Afrika te vereenselwig. Die geneeskunde het sy eie tradisionele doelwitte en waardes gekry en aangepas vanuit die uiteenlopende kulturele waardestelsels van die gemeenskap. Deur middel van sy nasionale en internasionale netwerke, inherente kennis en vaardighede, die leiding van 'n etiese kode, die Eed van Hippokrates wat as 'n belofte aan die publiek dien, beïnvloed die mediese beroep die land se gesondheidsorgstelsel – 'n meganisme van die regering om in 'n basiese menslike behoefte te voorsien.

Die mediese beroep moet daarom ingestel wees op die behoeftes van die gemeenskap in dieselfde mate as wat die gemeenskap die beroep behoort te ondersteun. Hierdie tesis ondersoek die rol wat die mediese beroep behoort te vervul in 'n Suid-Afrikaanse gemeenskap waar transformasie besig is om plaas te vind. Daar word geargumenteer dat dit net gedoen kan word indien die beroep sy waardes ondersoek en hom met die breër maatskaplike waardestelsels vereenselwig. Daar word verder geargumenteer dat 'n sigbare realistiese verbintenis van die mediese beroep tot openbare gesondheid tot die verbetering van sy openbare beeld sal lei. Dit is die optrede of nie-optrede van die meerderheid wat die publiek raaksien. Die meerderheid respondente in die meningsopname het aangedui dat hulle die transformasiebeleid vir gesondheid ondersteun, maar dat hulle verskil van die wyse waarop dit in werking gestel is.

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Table of contents		Page number
Executive summary		5
Introduction		10
Chapter One:	The general theory of values	
Section 1.	Values and their relevance	13
Section 2.	Classification of values	13
Section 3.	Values as they relate to medicine	15
Chapter Two:	The medical profession and values	
Section 4.	What are the traditional values of the medical profession?	17
4.1	The inequality in the medical relationship	18
4.2	The fiduciary nature of the doctor/patient relationship	19
4.3	The nature of medical decisions	20
4.4	The characteristics of medical knowledge	20
4.5	Moral complicity in the patient-illness relationship	20
Section 5.	What distinguishes the professions from other crafts?	21
Section 6.	Self-regulation by the profession:	22
6a.	Protection of the public	22
6b.	Professional discipline	22
6c.	Conflicts of interests	24
Chapter Three:	Medicine and society	
Section 1.	The goals of medicine	26
Section 2.	Medicine's identity: A social connection	29
Section 3.	Awareness of policy debates and changes	33
Section 4.	Public interest and common good	43
Section 5.	The nature of Interest Group Politics	44
Section 6.	Mechanisms and processes of interaction	47
Section 7.	Operational mechanisms of associations	48
Section 8.	Trade unionism versus professionalism	49

Chapter Four:	The medical profession and the Truth & Reconciliation Commission	
Section 1.	The medical profession and human rights:	53
1.1	Professional health organisations during apartheid	53
1.2	The organised medical profession	53
1.3	Institutional bodies	58
1.4	District surgeons as a TRC case study	58
1.5	The TRC verdict on the professional organisations' role	59
Section 2.	The values survey	60
Section 3.	Admission for training in the health sciences	61
Chapter Five:	Transformation challenges and the profession	
Section 1.	The South African organised medicine in perspective	67
Section 2.	The need for the medical profession to transform itself	69
Section 3.	The challenge of human resource distribution	73
Section 4.	Relationship between the profession and health authorities:	77
4a.	Development of a common vision	77
4b.	Development of trust and acknowledgement of differences	79
4c.	Proper management of conflict	80
Section 5.	Community involvement, role modelling and mentorship: Public duties of South African medical professionals?	81
Section 6.	The role of the medical profession	84
Conclusion		88
Appendix 1:	The Hippocratic Oath	90
Appendix 2:	Values Survey Questionnaire	91
References		95

Introduction:

'Although the art of healing is the most noble of all the arts, yet, because of the ignorance both of its professors and of their rash critics, it has fallen at this time into the least repute of them all.....'

(The Cannon of Hippocrates) ¹

This thesis examines the role that the medical profession should play in the transformation of our society. The method used is through a survey of the views of medical professionals working in different modes of practice and employment. The thesis looks at the traditional values of the medical profession as viewed by the doctors and also gleaned from the works of various international scholars on the subject of values. A total of 300 doctors, of which 94 responded, were surveyed for the purpose of determining which values they cherished most (from a list provided in the questionnaire), their awareness of social transformation policies and their views on what role the medical profession should play in that transformation.

The link between values and the profession's role was chosen for its historical significance. The medical profession has its own traditional values and goals whose aims are to prevent disease, cure illness, alleviate suffering and sustain human life for as long as possible. South Africa has just emerged from a period where the most basic of human rights were violated. Provision of and access to health care is one of these rights. The medical profession being an integral part of health care inevitably played a significant role during that period. This ranged from medical training to health service delivery. Section 7 of the thesis gives details of the hearings held by the Truth and Reconciliation Commission into the health sector, offering a glimpse into the role that the profession played during years of apartheid rule in South Africa.

The approach adopted in this thesis is from a theoretical discussion of values and how they relate to medicine. Sections 4 and 5 give a brief description of the concept of a profession and, by extension, professionals followed by a discussion on self-regulation of professions. The concepts of trade unionism versus professionalism are very significant in our political environment mainly due to the growing awareness of individual rights

enshrined in this country's constitution. The gains and influence that trade unions like the Congress of South African Trade Unions (COSATU) and the South African Democratic Teachers' Union (SADTU) have on government have not gone unnoticed by the medical profession. The membership of the South African Medical Association therefore has high expectations of its leadership who have a duty to lead the profession and to advise the health authorities in various aspects of the health system. The ability of the medical leadership to fulfill this role is heavily dependent on the internal politics of organised medicine. Sections 18 and 19 give an analysis of organised medicine and argue for a need for the medical profession to transform itself in line with the social changes taking place in our country.

A proposal is put forward in section 21 on how the profession could play a role in the transformation of our society. In the past 5 years, South Africa like any other country undergoing social change, had to endure problems of suspicion, distrust and antagonism between the new rulers and a number of professions. The medical profession has received prominence in this regard due to the fact that primary health care was declared as a priority by the new government dominated by the African National Congress. The profession although not openly opposed to Primary Health Care was very resistant to the way implementation was done. Countries like Nicaragua, Chile, Mocambique and Cuba faced similar problems upon attainment of their liberation. In some, like Mocambique and Cuba, there was eventually a mass exodus of doctors out of these countries. Talk of a 'brain drain' has been in the lips of academic and professional establishments for most of the first five years of the new South Africa. The new rulers therefore had reason to be hyper-alert, fearing that the same would happen to South Africa as it did in the above mentioned countries.

South Africa has, like Nicaragua, experienced a trickle of emigration, not a mass exodus. This brain drain has affected mainly the specialist and teaching medical fraternity. Other professions like engineering, architecture have also been hard hit by these immigrations. Reasons for immigration are varied but are underlined by the perceptions the medical profession harbours about the effects of social transformation policies on health care services. This directly affects their ability to maintain their living standards as resource

allocation affects their income generation. In certain instances like academic hospitals and universities, the shift of resources to primary health care has led to a reduction of budgets for research and international travel to conferences thus creating frustrations in those who administer at this level of health care. Power and control (highly prized by the professions) has therefore been eroded over the past few years, with the government taking responsibility for managing institutions like academic hospitals. Heads of departments at medical schools now have no control over the hospital beds, a crucial part to clinical teaching and training. This has left the university professors and heads of departments very despondent.

My argument in this thesis is that the medical profession has to find a way to respond to these challenges whilst fulfilling its public duty to assist government in providing good quality health care to all citizens. It is my opinion that the professions' foremost role, besides service provision, is to influence government policies and advise on the different aspects of service delivery. I consider the image of the medical profession to be very important in the South African context. This has a lot to do with the professions' past record and the answer may lie amongst others, in its involvement in public health issues on a proactive basis. In the Values Survey, many respondents identified several roles for the profession in public health and re-kindling of moral values in society.

Chapter One:

The general theory of values

Section 1: *Values and their relevance:*

Values are intangible things of the mind and are used as an expression of what people view as good living for them. They manifest in many ways and actions e.g. the way people express themselves and the acts they engage in while spending their time. Values are very abstract and exist as a state of mind in nature. They serve to both stimulate and constrain the person. I may want to respond in a rude manner to someone but feel constrained because I have been taught to respect others even when I feel deeply offended. Respect in this instance acts as a value that restrains me from a natural human reaction to provocation.

Values influence society, particularly in a democratic one, significantly conditioning the way society conceives of and goes about discharging its business ². The fabric of value is woven of the thoughts people entertain about their actions within the framework of their view of the good life. Humans, as rational animals, exhibit a tendency to plan their actions and to pass judgement on their doings ². A common understanding of what is being valued gives rise to aspirations of attaining what an individual and ultimately society views as being of good value e.g. health, security, comfort, respect and so on. These are espoused because although inanimate, they are viewed as enhancing the quality of life. Values therefore attain a universal nature and cut across many societies. This is despite the fact that a particular value may not necessarily be expressed in the same manner by two different societies.

Section 2. *Classification of values:*

There is no uniform system of classifying values, however they are often classified as personal, professional or work values, national, cultural etc. One of the methods used is with reference to the appropriate group of objects to which the value is taken to have application ² e.g. societal values encompassing economic justice

Name of value type	Explanation of what is at issue	Sample values
1. Thing values	Desirable features of inert things or of animals	Purity (in precious stones) Speed (in cars or horses)
2. Environmental values	Desirable features of arrangements in the (non-human) sector of the environment	Beauty (of landscape or urban design), novelty
3. Individual or personal values	Desirable features of an individual person (character traits, abilities & talents, features of personality, habits, life patterns)	Bravery, intelligence
4. Group values	Desirable features of the relationships between an individual and his/her group (in family, profession etc)	Respect Mutual trust
5. Societal values	Desirable features of arrangements in society	Economic justice Equality (before the law)

Table 1: Classification of values.

The central message in this type of classification is that each of the values mentioned has a domain that they become applicable to. The nature of the benefit at issue can also be used to classify values. The concept here is that each value is invariably bound to some form of benefit since humans value what they see as of benefit to attaining the good life. This relates closely to human wants, needs, desiderata and interests and can be correlated as follows ²:

Category of value	Sample values
Material and physical	Health, comfort, physical security
Economic	Productiveness, economic security
Moral	Honesty, fairness
Social	Charitableness, courtesy
Political	Freedom, justice
Aesthetic	Beauty
Spiritual	Piety, clearness of conscience
Intellectual	Intelligence
Sentimental	Love, acceptance

Table 2: Classification according to human wants.

Section 3. *VALUES AS THEY RELATE TO MEDICINE:*

The practice of medicine has always been value-laden and so has been the medical profession. Medicine is at its heart a moral enterprise heavily influenced by group, societal and individual values but also swayed by ‘things’ values. Medicine has always thrived and been guided by the principles of ethics which are statements of the right and good that derive from the ends and purposes of medical activity – healing, helping, and caring in a special kind of human relationship³. Ethics can therefore be taken to represent principles or value judgements that individuals within a profession ascribe to.

Abiding by such values and displaying them to society acts as a way of confirming that the individual doctor subscribes to certain values that are approved by society. The duties of medical doctors are the obligations that are voluntarily assumed by those who engage in the activity of medicine and who in consequence commit themselves to the ends of medicine³. Inherent to these obligations is values that are common and fundamental to the practice of medicine. These fundamentals, displayed in action by the individual doctor make it possible to establish a relationship of trust initially between the doctor and the patient. This trust enables the patient to rely on the doctor to make choices treating that are to the benefit of the patient.

The relationship between doctors and their patients takes many forms and has several elements, all based on particular values e.g. compassion plays a very important role in a medical relationship. Compassion in this instance is defined as the capacity of the doctor to feel something of the unique predicament of the patient, to enter into the patient’s experience of illness and as a result, to suffer vicariously the patient’s anxiety, pain, fear and so on³. This may be defined as value of internal origin that has intellectual honesty as part of it. Intellectual honesty in compassion is different in that it is a duty the doctor is required to conform to as a guide, namely ‘always disclose accurately to your patient and colleagues the extent of your knowledge and ignorance’.

Virtues (described as value judgements) of moral excellence, uprightness and goodness are based on the values that individuals hold and have for many centuries been a pillar of the practice of medicine. Moral excellence and uprightness are important elements of professional discipline. Why should a drunken doctor be more reprehensible than a similar lapse in a docker? The answer lies in the fact that conduct unbecoming in a professional person leads rightly or wrongly to a loss of confidence by the public and once respect is lost the professional person is unable to exercise his / her skills to the full. Clients and patients will hesitate to give information to, or take advice from, someone they do not trust and respect. Without respect, professions are helpless⁴.

Patient advocacy is an integral part of the Hippocratic Oath that each doctor takes on being confirmed as qualified to look after the lives of patients. It is like a right of passage with connotations that even in hardship the patient's interests come first. However, the struggle for survival in the marketplace has placed demands on medical professionals to transform themselves into entrepreneurs, thus the conflict between altruism and self-interest of the doctor. This dilemma was clearly illustrated in 1988 when Albert Jonsen in his George Washington Gay Lecture at Harvard examined the conflict between altruism and self-interest³. His conclusion was that *'history and philosophy of medicine give moral meaning to the past; moral confidence in the future can only be achieved by the scientists, administrators, and practitioners of medicine who understand its moral meaning. It is their responsibility to revise the institutions and practices created in the past without loss of moral meaning. Those responsible for the revision of medicine's past to meet its future must have confidence that they can make those revisions without sacrifice of its essential values'*.

Doctors continuously face this dilemma as many wish to still act in the patient's interest and keep to the idea of a profession. At the same time other doctors see no reason why they should be held to ethical standards higher than anyone else. Values, although originating from individual perspectives, are carried in perpetuity through societal structures. For doctors to advance this, the act or choice of belonging to a profession enables them to identify with particular values inherent in that profession. It is therefore the practice and doctrine within the profession that serve to entrench the value system.

Chapter Two:

The medical profession and its values

Section 1: *What are the traditional values of the medical profession?*

This question assumes that the values ascribed to the profession are universal and therefore common to all medical practitioners. This view is re-enforced by the fact that traditionally medical doctors perform a rite of passage when they pledge through the Hippocratic Oath to uphold its declarations. Taking this oath is figuratively similar to a Xhosa custom of circumcision – a man can never be fully accepted by his community as a fully-grown man unless he undergoes this. This goes with a pledge to be a good citizen, and that the community can depend on you to play a constructive role in uplifting it. Similarly, taking the Oath confers to a young doctor the feeling and acknowledgement by the profession of acceptance into the family of medical scientists whilst at the same time pledging to be a responsible doctor who will uphold the ethos of the medical profession. The oath – *not the degree* – symbolises the graduate's formal entry into the profession³.

Values are very difficult to characterise precisely because they are of 'a non-objective nature', have great flexibility, subtlety and ambiguity. They are intangible, nebulous concepts that get influenced a lot by objective conditions under which doctors have to survive. It is not surprising to find that there may be some subtly different opinions as to what constitute the core values of the medical profession. 'Value is offered to man not as a mere object of contemplation and analysis, but as demanding admiration, reception and fulfillment'⁸. What is referred to as traditional values of the medical profession is based on the Hippocratic Oath that symbolises the graduate's formal entry into the profession. Even though currently there are suggestions from internationally reputed scholars, human rights activists, ethicists etc to revise the Hippocratic Oath, it is still regarded as the ethical foundation in the making of a doctor. Certain social norms render parts of the Oath irrelevant when taken in the context of objective realities existing within particular societies.

The antagonists of the South African Abortion Act draw the attention of medical doctors who perform termination of unwanted pregnancies to the clause in the Hippocratic Oath that requires the doctor to 'maintain the utmost respect for human life from the time of conception'. Clauses like these are also under attack by those who would like to see the 'values standard' of the medical profession revised to bring it in line more with a better human rights culture.

The argument advanced here is that the Oath is a public promise that serves as guidance in the management of human relationships in the practice of medicine. This relationship inevitably imposes some moral constraints or imperatives in the form of³:

1.1 The inequality in the medical relationship:

The value for human life permeates even the most famous, the most fearless and the weakest in society. Everyone becomes anxious, fearful and dependent when illness strikes. This results in vulnerability and an experience of a loss of freedom creating a situation where the patient literally gives commanding powers about his/her life to the attending doctor. The doctor therefore has to take decisions based on his assessment that will have a profound effect on the patient. This may either exacerbate or alleviate the patient's anxiety. It is a responsibility that is not easy to carry through.

This has haunted the medical profession over many years, more so with the rise of a human rights culture that encourages patients to take decisions about their lives, treatment and medical interventions based on 'credible professional' advice. The doctor's role is to share his / her knowledge so as to better inform the patient's decision. This makes the knowledge and expertise to enter the realm of being public property. The doctor cannot refuse to offer it when needed for the benefit of the patient or society because it is not intended primarily for personal gain, prestige or power³. The doctor/patient relationship is now maturing to that of a partnership with the patient regarded as an integral part of the decisions about his / her illness.

The BMA in its Core Values Survey, following a conference held in November 1994, found that ⁹:

- a) 69% of respondents supported the view that the doctor/patient relationship should be a partnership based on mutual trust and openness.
- b) 27% felt that the relationship would never be an equal one because the knowledge doctors have will always place them in a position of advantage.
- c) 59.4% felt that doctors should present patients with all available information about their illness and allow them to make choices about treatment, including refusing treatment if they wish.
- d) 36.5% believed that there are circumstances where it is in the patient's interest to withhold from them information about their illness.
- e) 76.5% believed that doctors are patients' advocates and should guide them through the system, speaking on their behalf if necessary.
- f) 16% felt that doctors are part of the health care system in that the way they are trained encourages them to withhold information from patients and that patients should be allowed to bring an independent advocate to consultations if they wish.

This survey had 812 respondents.

1.2 *The fiduciary nature of the doctor/patient relationship:*

In conditions of vulnerability the patient has no alternative but to trust the doctor. Under such conditions the public promise requires the doctor to be selfless and avail his/her knowledge and skill to the service of humanity. The doctor has to display a level of discipline that will make patients feel comfortable and convinced that he/she has their interest foremost. This is probably the most important aspect of the relationship as patients expose and reveal themselves to be healed and helped. They expose their bodies, minds and even secrets (that have a potential of wrecking their social lives if someone else would know) to the doctor in their bid to get the professional help that will bring about an improvement in their health.

1.3 *The nature of medical decisions:*

As mentioned earlier, the patient's moral right to self determination must be respected at all times. The assertion in many instances is that the doctor has an upper hand in the medical relationship. As most medical decisions are a mixture of technical and moral considerations, doctors must always be conscious of the fact that the good of the patient is the end and purpose of this relationship. The physician must be scientifically correct in making a diagnosis, prognosis, and choice of therapy but, at the same time, his or her recommendation must be for the patient's good ³.

1.4 *The characteristics of medical knowledge:*

The medical knowledge and skill imparted to doctors whilst in pursuit of preserving human life generates obligations and privileges. Society generally permits the invasion of the privacy of the sick patients on the basis that:

- a) Practical knowledge gained, even if intervention is unsuccessful, will help contribute to the care of the sick in future.
- b) Such invasion of privacy is regulated and guided by the confidentiality that the Oath requires of a doctor.

1.5 *Moral complicity in the patient-illness relationship:*

In the doctor's display of a caring ethos is the notion that through medical intervention the doctor becomes morally interwoven in the complex relationship that the patient has with his/her illness. He/she 'de facto' becomes an accomplice in whatever is done for good or ill to patients ³.

This healing relationship offers an explanation as to why doctors should be held to higher standards of effacement of self-interest than others in society should. Theirs is a profession as value based as that of the Ministers of Religion. This relationship is also

subjected to numerous challenges, most notably the resources for health care and entrepreneurship of the medical doctors. Not only does commercialism affect this; it also impacts on the collective professional responsibility. The collective professional responsibility is encapsulated in what are regarded as the goals of medicine.

Section 2: *What distinguishes the professions from other crafts?*

The monopoly of learning belonged from the very early years of civilisation almost exclusively to the Church. The acquisition of knowledge through other avenues like universities became possible during the renaissance. In the nineteenth century, with the new social, economic and health needs of the population and extension of knowledge, there came the rise in the examination system and the idea of formal professional qualification ⁴. This, over many years, led to what is now referred to as professionals, a group of people characterised by qualification, which is an indicator that they possess special knowledge and have an implied or tacit contract with society to supply the public with a particular service. Such public service needs are determined by society and influenced in many instances by the professions themselves whose knowledge is ever expanding.

Members of the professions take it upon themselves to constantly reappraise their knowledge, tasks and skills so that they can remain relevant to the service they provide. This in turn serves to characterise the profession, using knowledge and skills that can only be acquired internally. This was also presumably the aim of Hippocrates when he urged practitioners ‘to teach the skills only to his children and those of his colleagues and none else’. This interdependence between society and the service provided by the medical profession, like any other profession, emphasises the fact that without society the concept of a profession has no meaning.

Sir Harold Himsworth ⁴ identified this when he commented that:

‘Essentially the concept (of a profession) implies a recognition by society that if its needs are to be met in a particular respect, then the body of men undertaking this obligation must

be given special consideration. In effect a tacit social contract is implied; obligation on the part of the society to accord the professional man such status, authority and privilege as shall be required for him to discharge his obligations. Only in so far and for so long as this implicit contract is observed will the profession in question survive’.

(Note: gender sensitivity was apparently not an issue because medicine was a craft for men during his times)

There is general acknowledgement and acceptance that the following form the basic characteristics of a profession, and when applied to the medical profession means:

- a) That the profession possesses a body of knowledge and skills based on a particular period of education and training and that such knowledge / skills are acquired so that particular needs of society can be met.
- b) That the profession shares a code of ethics / conduct which indicates how individual members relate to one another, how patients should be served and the acceptable social attitudes
- c) That the members of the profession become licensed through a specific mechanism undertaken by a body derived from the profession itself.

These characteristics symbolise the willingness of the medical professionals to subject themselves to certain standards of social morality higher than those expected from ordinary citizens. To enhance this, they work together to constantly improve knowledge and the skills that would be difficult to maintain working individually. This is done with a clear understanding that the mere possession of knowledge and skills does not necessarily win the trust and affection of the public. The fact that professions cannot exist without society means that they have to adapt or subscribe to certain societal values. This produces a dilemma whereby a conflict develops between individual professional and the general societal interests.

Section 3: *Self-regulation by the medical profession:*

Our medical profession has developed mechanisms of regulating the conflict between individual professional and societal interests through adoption of policies designed to address the following:

3.1 Protection of the Public:

In South Africa, as in many countries internationally, the medical profession has established mechanisms from within its ranks to proactively deal with such conflicts of interests. The establishment of the Medical and Dental Board of the Health Professions Council of South Africa is a mechanism to regulate the conduct of professionals in the interest of the public. This is a statutory body established by an Act of Parliament (Act 56 of 1974). The council has several powers including de-registration of professionals found guilty of misconduct and also ensuring maintenance of standards of professional competence and so on.

3.2 Professional discipline:

The medical profession has organised itself so that it can take some of the responsibilities and serve as a watchdog over members who voluntarily join its organised formations. Self-regulation is a tool that has been applied by the medical profession for this purpose and makes it possible for the profession to publicly demonstrate how serious it is about matters of discipline. This earns the profession respect because without public respect, professions are helpless.

The organisations therefore serve as conduits through which the profession can express directly or indirectly that it subscribes to the wider societal values. These functions are carried out through formalised structures e.g. the South African Medical Association's Human Rights, Law and Ethics Committee, the Peer Review Committees of the Independent Practitioners' Associations and SAMA branches. The HPCSA has recently established a Multi Professional Peer Review

Committee whose first mandate was to formulate policy on Perverse Incentives in healthcare.

3.3 Conflict of Interest:

If the concept of a social contract is valid, do medical doctors have a right to protest? The self-imposed obligation to serving and fulfilling society's health needs introduces certain challenges. A medical professional employed by the Department of Health has similar responsibilities as a colleague who is self employed as an Independent Practitioner in so far as contributing to the attainment of health by the citizens. What differ are the conditions under which the two have to operate under, thus influencing these responsibilities. Both serve the communities' needs but are faced with slightly different demands. This is worsened by the rapid social and economic changes faced by all. Transformation of health care in South Africa demands that doctors and patients adjust, a condition dictated to by the diminishing resources for health funding. The explosion of knowledge, better access to information, technological advances in health and an evolving human rights culture have empowered patients producing what can be termed as 'demanding patients'.

The effect on the medical community has largely been a stressful one considering the social importance they have enjoyed over many years, being almost unheard of that a doctor could be called on to account by patients. Doctors have become anxious and possess a feeling that the reward they get does not justify or match the level of service they deliver under very stressful conditions.

Another area of conflict is the classification of health services as Essential Services. In terms of the Labour Relations Act workers that are classified as providing an essential service are legally barred from embarking on industrial strikes. This is seen by many doctors as conflicting with the right of individuals as enshrined in the country's constitution. They however have very stringent procedures to follow before they can embark on such action but it is still their responsibility to provide cover for emergency

service during the industrial action. The process involves particular steps from mediation to arbitration that is either voluntary or compulsory ⁵.

The issue of strikes is an area that the medical profession itself is not comfortable with and continues to draw mixed reactions. Taking the Hippocratic Oath is a commitment by a doctor to look after the interests of his/her patients before anything else. The Zimbabwean doctors who went on strike over salaries in 1999 were faced by this dilemma. Going on strike as a doctor is viewed by the public as neglecting one's duties and commitment to the patient's interest in favour of individual interests. The statutory requirements can indirectly be interpreted as a way of legally enforcing this aspect of one of the medical profession's oldest values – preservation of life.

The system of compulsory community service by young medical doctors introduced under the tenure of Dr NC Dlamini-Zuma as National Minister of Health brought to the fore the complexity of the concept of a social contract. On the one hand poor rural communities were delighted at the prospect of getting services of doctors whilst the young doctors cried foul to the extent of considering mounting a legal challenge in the court of law. It is also significant that the majority, 94.68%, of the respondents to my survey viewed community service as appropriate, realistic and relevant. This policy brought to light the deep-seated conflict within doctors regarding their obligations to society. This is not only confined to the medical profession; the legal, engineering and other professions are faced with the same challenges.

As the debate on medical community service raged on, parallels and comparisons were drawn with other professions with questions asked why the government was singling out medical doctors whilst rural communities need good roads and legal services to help communities with their traditional legal systems. These points act as stressors to the medical profession that is struggling with its own internal dynamics. Above all, doctors resent government authority.

Chapter Three:

Medicine and Society

Section 1: *The Goals of Medicine:*

‘Economic, social and scientific pressures on medicine in the twentieth century are forcing policy makers throughout the world to attempt medical and health care reform. But these efforts will fail, or not reach their full potential unless a new light is turned on the values at the core of medicine’¹⁰. This statement encapsulates the reality that both doctors and patients are faced with. This has led to a number of organisations and/or institutions to examine and research the subject of values in medicine. The Hastings Center, an Ethics Research Institute based in New York set up an international project in 1996 to question afresh the traditional goals of medicine. Their team, comprised of representatives from fourteen countries, concluded that there are four goals of medicine which, by representing the core values of medicine, will ‘help medicine maintain its integrity in the face of political or social pressures to serve anachronistic or alien purposes’.

The Hastings Team identified the following four goals:

- a) The prevention of disease and injury and promotion and maintenance of health.*
- b) The relief of pain and suffering caused by maladies.*
- c) The care and cure of those with malady and the care of those who cannot be cured.*
- d) The avoidance of premature death and the pursuit of a peaceful death.*

Their report also alludes to ‘Mistaken Medical Goals and Misuse of Medical Knowledge and Skills’. This refers mainly to unacceptable uses of medical knowledge in areas such as public health like the use of public health information to justify coercing large groups of people into changing their unhealthy behaviours. The conclusion is that regardless of political or geographic barriers, medicine should aspire to:

- a) be honourable and direct its own professional life;*
- b) be temperate and prudent;*
- c) be affordable and economically sustainable;*

- d) *be just and equitable;*
- e) *respect human choice and dignity*

The economic, social and scientific pressures referred to earlier, have in recent years introduced another dimension not catered for in Medicine's public promise, the Hippocratic Oath. There is no doubt that the healthcare systems worldwide are under stressful influence of what is referred to as the market. Private health care resists regulation by government authorities strongly arguing that 'market forces' must be left to play a regulatory role. The concept of a market in health care sounds like an alien concept. It can probably be best interpreted in theory as:

- a) A way of allowing individuals, not government, to make their own choices when purchasing health care services / products;
- b) A way of promoting the most efficient distribution of health care products and services brought about by open and private competition;
- c) And as a means of devising incentives and disincentives for modifying supply and demand behaviour in health care.

Over many years this has been proved to be a fallacy because the lack of regulation has led to spiraling health care costs, making health inaccessible for the majority who cannot afford the exorbitant private fees. Concepts of cost-containment and cost-effective health delivery mechanisms surfaced in the private health sector as mechanisms to address this reality. The United States of America, recognised as a leader in the Managed Health Care systems, is currently involved in debate with proponents and opponents of these types of cost containment mechanisms pitched against each other. Coupled with satisfying personal desires of patients in terms of choice of health care, there has also been the ever-increasing desire by the health care providers to satisfy their economic/profit motives. The medical profession resents being subjected to 'undue' control by health funding administrators citing their 'patient advocacy' role / function as being above economic considerations. Translated into real terms this means that a doctor should not be limited in any manner when considering appropriate treatment for the patient. With the worsening economic situation, the cost of health care becomes a serious factor.

South Africa is no different. The medical profession has also been deeply divided on how best to address their economic interests. It is not rare to find the young people aspiring to be doctors citing economic reasons for why they would choose medicine as their first choice career. There is currently legislation pending in our country on the issue of private General Practitioners dispensing medicines to patients. The government argues that doctors are not trained to dispense medicines and will therefore not be allowed to continue with this practice if a doctor is in the proximity of a pharmacy.

The covert doctors' economic interests in dispensing of medicines have always been cited as a reason for considering this legislation. The common practice is that a doctor will prescribe to a patient covered by some form of medical insurance (Medical Aid Scheme) a generic type medicine but submit a claim for an ethical type equivalent. Generic medicines are replicas of ethical medicines whose patents have expired and these medicines generally cost far less than the ethical brands' prices. Supplying generic medicine but charging the Medical Aid Scheme the price of an ethical brand constitutes fraud. Unfortunately, some doctors engage in this practice in pursuit of their economic interests.

Besides this extreme example, the market theory in medicine has other forms of hazards. These include the introduction of an alien set of economic values into the institution of medicine whose inherent ends have historically been philanthropic and altruistic, not commercial. Despite the prevalent belief by some doctors in the concept of a free market in health care, the resultant tendency is the decrease in the patient's choice. This is influenced by the gap between the rich and poor as the fees are set to specifically derive maximum benefit from the rich patients thus services are pitched at a level to suit those who can afford the expensive fees. The weakening of those parts of health care systems dependent on government (due to the scarcity of resources), the encouragement of expensive and thus profitable forms of high technology medicine rather than the less technology-intensive disease prevention and primary care programs contribute to the economic pressures faced by health systems. With doctors, being the nerve centre of health care, are perceived as being the drivers and beneficiaries of economic pursuits in health care. This finally has an effect on values espoused in action by the profession. A perception is created that it is not only rewarding but also profitable to be a medical

doctor. This puts the integrity of the medical profession at stake. In my survey of 300 doctors with a response rate of 31% (94 respondents) 11,70% indicated that wealth as a value is the most cherished by them in contrast to the 25.54% who rated it as least cherished. The British Medical Association in its Core Values survey found that financial reward as a reason for becoming a doctor accounted for 9,4% of their respondents.

Section 2: *Medicine's identity: A social connection.*

How much respect should doctors be accorded by their patients and to what extent and form should doctors respect their patients? Medicine has developed to be a high status career in many societies due to the fact that when illness or disease strike, everyone of us human beings turns to someone for help. This refers to all types of practices, Western and Traditional, as we have come to differentiate them in South Africa. During my years as a General Practitioner in Khayelitsha, Cape Town, it was not uncommon to be confronted by a situation where a patient consults me after spending considerable time visiting 'a traditional healer'. The majority of black patients use of the services offered by traditional healers but this has for a long time been frowned upon by the medical profession.

A prominent black Soweto medical doctor, Dr Nthato Motlana was quoted as referring to traditional healers as 'Mumbo Jumbos' in parliament only a couple of years ago, infuriating them in the process. This is despite the fact that the majority of the population in this country is black people and it is part and parcel of their culture to consult with traditional healers and sangomas. Dr Motlana's comments represented what has been the attitude for many decades towards what is part and parcel of cultural values for a certain section of society. On the other hand there are doctors who double up as medical doctors and traditional healers, indicating the acceptance of and ability of such values to co-exist.

Medicine begins with the doctor-patient relationship, which in turn generates for its viability inherent values – such as the doctor-patient bond – to maintain and strengthen itself¹¹. The doctor-patient relationship is the most cited reason when doctors try to ward off interference in what they regard as encroaching on their independence. Medical doctors are born and brought up as any other normal citizen and can therefore not escape

being highly influenced by the mores, values, politics and economic pressures of society in which they live. Their trade is kept alive economically by the large amounts spent by government; individuals, private industry and many doctors can easily find themselves dancing to the tunes of what they perceive as their financiers. This is heavily influenced by the social structure in which the profession exists.

Many social values, not necessarily medical in nature have found their way to influencing medical decisions and interventions e.g. consent is now paramount in medical research. Empathy, kindness, respect and value for human life are fundamental to the practice of medicine. In return doctors value being respected by patients and communities in which they ply their trade. 23.40% (22 respondents) in my values survey rated respect by the community as their most cherished of the values. The fact that medicine has its own inherent values that society recognises and sees benefit in their maintenance, makes medicine to survive in the face of numerous challenges it faces. This allows patients to understand, appreciate and be in a position to judge what kind of medical care they can expect from doctors. It also allows them to help keep the medical profession in check by expressing openly what society expects from them and exerting pressure on the profession to modify its values in tandem with changing social norms and values.

There is a view held by some that medicine should hold onto its inherent values thus allowing it to resist social domination or manipulation, and to give medicine its own direction and doctors their own integrity, independent of social values. The argument further goes on to suggest that medicine, through this, will inevitably be influenced by the values and aims of societies in which it finds itself but without societal values influencing the medical ones. Another viewpoint is that medicine can be best thought of as an evolving fund of knowledge and a changing range of clinical practices that have no fixed essence and thus will reflect the times and societies of which it is a part of. The values that medicine will espouse will therefore be indicative of what society sees as being fit to use medicine for. Such values will also be subjected to the same constraints that mark other social institutions. The South African experience illustrates this challenge perfectly. Medicine is being called upon to serve the interests of the majority of the people who are in land locked rural areas better than it has ever done before. Emphasis is now on Primary

Health Care and the team approach, concepts that traditional medical training in this country has never emphasised or have been taught and interpreted differently by the trainers. The call to serve the poor has come via a policy that requires doctors who have finished their internship year to serve a year of Community Service, mostly in rural hospitals. My survey revealed that 98.9% (93 respondents) are aware and supportive of the policy even though some felt that the way it was introduced was not the most friendly way of handling public policy by the Department of Health.

Medicine must constantly revisit its values and ensure that these are in keeping with what society expects of the profession. There is inter-dependence between societal values and what the professions hold as values of their own. The bond that develops in this relationship is universal and is based on trust. In the case of the medical profession, the doctor-patient relationship is a gateway to a sea of mutually beneficial value judgements that serve to enhance the goals of medicine irrespective of how pluralistic the society in question is. Medicine ought to develop and influence its own history taking internal corrective measures where it feels that it has erred.

A profession without a common vision or espousing too divergent values becomes very vulnerable and can easily be victimised and misused by society as the case was with Apartheid when the medical profession was used as a tool in denying people access to health care. The profession willingly participated in rendering treatment to patients in segregated health facilities. Some members of the profession went as far as being part of the machinery for human rights abuses. The most celebrated South African example is the Steve Biko case. The unprofessional conduct of the doctors involved in Mr. Biko's treatment and the SAMDC's failure to take appropriate action drew the attention of the South African and international medical fraternity to the role of health professionals in the neglect or the overt abuse of patients' human rights¹². Another high profile 'medical professional' case is currently being heard in Pretoria involving Dr Wouter Basson, dubbed 'Dr Death'. Dr Basson, a cardiologist based at the Pretoria Academic Hospital is facing charges of fraud, murder and drug dealing.

Despite the serious nature of the allegations against Dr Basson, the medical fraternity has so far failed to take even symbolic action like suspending his registration with the Statutory Council or his membership of the national medical association. The most commonly cited defence is that he has not yet been found guilty and the case is sub-judice. He is therefore still in the register of the Medical Council as a practising clinician. The question that arises is whether this is an accurate reflection of the medical profession's unwillingness to acknowledge and assimilate what the society values.

There are other spheres of life in which some sections of the medical profession have found it difficult to come to terms with changing societal needs and conflicts in values. Some of these may be seen to be in conflict with the broad goals of medicine and influenced by a number of factors like the religious values that individual doctors may have. The example is the emotive Abortion Act passed by parliament in 1996. Some doctors have refused to perform the procedure citing their religious beliefs as an inhibiting factor. However, in certain instances doctors, although prepared to perform abortions on patients' request, could not perform the procedure due to the dominant opposing views of the community where the doctor works.

Medicine cannot escape being part of the society where it exists and by extension, will be influenced by the dominant values held and promoted by that society. It however has its own values. It needs to have its own internal compass and abiding values, which will be stronger if resting upon its traditional and largely universal goals¹¹. The challenge for medicine specifically in our country is for it to actively demonstrate that it is aligned with the rapid changes that are evident in society. South Africa is a beacon of hope not only in Africa but all over the world for its commitment to a human rights culture and peaceful resolution of conflicts. All professional sectors of society are involved in some introspection work of some kind, questioning the future of their own professions in view of the new realities. No profession can successfully position itself for survival into the unknown or even uncertain future without scrutinising its social foundations. The medical profession could be regarded and compared to other professions that can be classified as noble if for anything but for its goal of preserving and valuing life.

The traditional values of the medical profession have to exist within the social framework, adapting to the needs and expectations of contemporary society. The survey I conducted was aimed at:

- a) *Determining which of the values (from a list provided) the medical profession cherishes most*
- b) *Testing awareness of the respondents about some of the policies adopted by the government and statutory bodies to reform health care*
- c) *Their views on the policies*

Section 3: *Awareness of policy debates and changes:*

Each respondent was asked to indicate awareness or lack thereof of a number of policy issues emanating from either the Department of Health, Health Professions Council or Health Care Funding agencies. The policies covered a range of issues affecting:

- a) Education and training of medical students;
- b) Continuing education of practising professionals;
- c) Health service delivery;
- d) Maintenance of professional competence;
- e) Mechanisms of funding health care;

All these policies are part of the components of transformation of the health care environment both in the public and private health sectors.

<i>Policy</i>	<i>Yes</i>	<i>No</i>
District Health System	70	24
Licensing of practices	82	12
Accreditation of health facilities	89	5
Re-certification for professional competence	92	2
Medicines: Generic substitution	87	7

Amendment to the Medical Schemes Act	71	23
Managed Health Care Systems	80	14
Changes to Medicines Control Council	67	27
Community Service by young graduates	93	1
Continuing Professional Development	66	28
Changes to the medical undergraduate curriculum	50	44

Table 7: Policy awareness

Policy	Variety of comments.
District Health System	Unworkable system. Hope it will improve delivery. Will only work within a National Health System.
Licensing of practices	Interference with trade freedom. Good, will force adherence to standards and will eliminate negative competition.
Accreditation of health facilities	Good, will guarantee quality. Improvement of standards. Can lead to corruption and bribery
Re-certification for professional competence	Provide safety for patients. Bad idea that will turn HPCSA into a 'police force'
Medicines: Generic substitution	Good, will save millions of rands. Ensure maintenance of quality. Good as long as doctor has the right to decide on choice of appropriate drug – ethical or generic.
Amendment to the Medical Schemes Act	Good idea only if implemented transparently. Bad, will destroy Medical Aids.
Managed Health Care Systems	S. Africa cannot afford it. Good only if benefits are passed to patients. Can be good if managed properly
Changes to Medicines Control Council	Sounds good for the country. Too many laws will make control difficult, not sure about efficiency. Good provided that

	officials cooperate with the profession.
Community Service by young graduates	Will benefit doctors in long run. Discrimination against doctors. Unconstitutional policy. Good for patients / poor communities.
Continuing Professional Development	Very good idea. Do not need to be policed.
Changes to the medical undergraduate curriculum	Agree with initiative.

Table 8: Range of opinions

The responses to these policies give an indication of the very diverse nature and the background of the medical professionals in South Africa. While a number of respondents expressed extreme support for these transformation measures, some respondents expressed the feeling that some of the changes cause them distress due to uncertainty about the future. However, the majority seems to be aware of the reasons why the health reform policies have to be implemented. The case in point is the compulsory community service for medical doctors in their post-internship year. Although unhappy about the way it was introduced (the majority opinion is that there was no adequate consultation with the young doctors about this), 94.68% of the respondents agree that it was a necessary and correct step for the government to take.

In a country rich in cultural diversity, an extensive history of racial disharmony and human rights abuses, it is appropriate for us to examine what values the medical profession holds dear and how these relate to the transforming South African society. As the subject of values is vast, a set of values was listed and each respondent was asked to rank them in accordance to preference. The values identified were:

Value	Percentage
1. Honesty	31.9
2. Caring ethos	30.9
3. Integrity	26.6
4. Professionalism	24.5
5. Respect by the community	23.4

6. Credibility	22.3
7. Scientific excellence	15
8. Recognition by peers	11
9. Wealth	11
10. Clinical independence	10.6
11. Success	8.5

Table 9: Ranking of values according to survey results

The results demonstrate the medical profession's belief in upholding certain values that are commonly pursued by society like honesty, caring, integrity, respect and so on. The British Medical Association's Core Values Conference also identified a set of values that it asked respondents in a questionnaire to rank in order of importance. The British medical profession responded as follows (in order of importance):

- a) Competence of the doctor*
- b) Caring attitude*
- c) Commitment*
- d) Integrity*
- e) Compassion*
- f) Responsibility*
- g) Confidentiality*
- h) Spirit of inquiry*
- i) Advocacy for patients*

Most respondents in the BMA survey added some values they felt were dear to them:

- a) Empathy*
- b) Humanity / Moral values / Decency*
- c) Sense of service / dedication and loyalty to the profession*
- d) Tolerance of all types of people*
- e) Altruism / selflessness*
- f) Courtesy / politeness / good manners*

These values are many ways similar to what the medical profession in South Africa espouses. Medicine has both global and particular features and goals that ought to be common to all cultures, and goals that are appropriately unique to different cultures¹⁰. Irrespective of the fact that basic training in medicine is universal in approach, transformation of society has an effect on medicine. This overrides other factors within medicine that have a tendency to keep that universality. Societies undergo different transformation processes that are in keeping with the history of particular countries and are also heavily influenced by the prevailing cultures. Some values may not necessarily change but the bearers of such values may be under such extreme pressure that for a variety of reasons the bearer decides to suppress the value. The values given high ranking in the survey I did and that done by the BMA are similar but when looking at the South African situation, one would wonder why the Truth and Reconciliation Commission issued such a scathing report on the medical profession's role during apartheid years.

Honesty, caring, integrity, professionalism and so on are a component of the building blocks enabling the profession to uphold human rights. However the medical profession did not openly display these at the time that the majority of their fellow citizens were subjected to human indignity. The reasons may well be very varied, ranging from fear of reprisals by the oppressor authority to active belief and support for what apartheid policies represented. It therefore stands to reason that the prevalent community values easily find their way into the professions, whether it be for professional, economic or others reasons.

The traditional values in medicine have evolved over many centuries but still retain some universality. The profession itself has put in place structures and adopted a number of resolutions from time to time to monitor and manage the progression and protection of these. The way the respondents ranked the values they most cherished supports the view that medicine, after all, is a moral community³. Alasdair MacIntyre³ stressed that the interrelationship of ethical virtues and principles relies upon the grounding of both in the community and its values. It is an indication that by cherishing these values many doctors still believe in the concept of a profession guided by a set of values linked to those that the community or society believes in.

Values survey individual ranking results:

	Rank:	Total score by rank:	Percentage
<i>Respect by community</i>			
<i>Least cherished</i>	1	2	2.13%
	2	3	3.19%
	3	2	2.13%
	4	8	8.51%
	5	8	8.51%
	6	8	8.51%
	7	7	7.45%
	8	9	9.57%
	9	7	7.45%
	10	6	6.39%
	11	5	5.30%
<i>Most cherished</i>	12	22	23.40%
No response		7	7.46%
		94	100%

<i>Recognition by peers:</i>			
<i>Least cherished</i>	1	5	5.32%
	2	6	6.38%
	3	13	13.83%
	4	4	4.26%
	5	5	5.32%
	6	3	3.19%
	7	5	5.32%
	8	10	10.64%
	9	7	7.45%
	10	11	11.70%
	11	6	6.38%
<i>Most cherished</i>	12	11	11.70%
No response		8	8.51%
		94	100.00%

<i>Honesty:</i>			
<i>Least cherished</i>	1	9	9.57%
	2	6	6.38%
	3	6	6.38%
	4	4	4.20%
	5	2	2.13%
	6	2	2.13%
	7	6	6.38%
	8	6	6.38%
	9	2	2.10%
	10	8	8.51%
	11	8	8.51%
<i>Most cherished</i>	12	30	31.90%
No response		5	5.30%
		94	100%

<i>Wealth:</i>			
<i>Least cherished</i>	1	24	25.54%
	2	6	6.38%
	3	3	3.19%
	4	5	5.32%
	5	5	5.32%
	6	6	6.38%
	7	6	6.38%
	8	5	5.32%
	9	5	5.32%
	10	6	6.38%
	11	4	4.26%
<i>Most cherished</i>	12	11	11.70%
No response		8	8.51%
		94	100.00%

<i>Clinical Independence:</i>			
<i>Least cherished</i>	1	2	2.13%
	2	4	4.26%
	3	5	5.32%
	4	9	9.57%
	5	4	4.26%
	6	12	12.77%

	7	9	9.57%
	8	11	11.70%
	9	8	8.51%
	10	7	7.45%
	11	5	5.32%
<i>Most cherished</i>	12	10	10.63%
No response		8	8.51%
		94	100.00%

Success:			
<i>Least cherished</i>	1	5	5.32%
	2	12	12.76%
	3	3	3.19%
	4	7	7.45%
	5	5	5.32%
	6	4	4.26%
	7	7	7.45%
	8	7	7.45%
	9	5	5.32%
	10	11	11.70%
	11	9	9.57%
<i>Most cherished</i>	12	8	8.51%
No response		11	11.70%
		94	100.00%

Scientific Excellence:			
<i>Least cherished</i>	1	2	2.13%
	2	3	3.19%
	3	9	9.57%
	4	3	3.19%
	5	11	11.70%
	6	5	5.32%
	7	5	5.32%
	8	8	8.51%
	9	9	9.57%
	10	13	13.83%
	11	3	3.19%
<i>Most cherished</i>	12	14	15%
No response		9	9.57%
		94	100%

Professionalism			
<i>Least cherished</i>	1	5	5.32%
	2	2	2.13%
	3	4	4.26%
	4	6	6.38%
	5	6	6.38%
	6	3	3.19%
	7	5	5.32%
	8	10	10.64%
	9	6	6.38%
	10	11	11.70%
	11	6	6.38%
<i>Most cherished</i>	12	23	24.47%
No response		7	7.45%
		94	100.00%

Integrity:			
<i>Least cherished</i>	1	6	6.38%
	2	11	11.70%
	3	2	2.13%
	4	3	3.19%
	5	4	4.26%
	6	5	5.32%
	7	5	5.32%
	8	2	2.13%
	9	3	3.19%
	10	13	13.82%
	11	11	11.70%
<i>Most cherished</i>	12	25	26.60%
No response		4	4.26%
		94	100.00%

Credibility:			
<i>Least cherished</i>	1	0	0%
	2	3	3.19%
	3	6	6.38%
	4	9	9.57%
	5	8	8.51%
	6	7	7.45%
	7	4	4.26%
	8	9	9.57%
	9	9	9.57%
	10	9	9.57%
	11	3	3.19%
<i>Most cherished</i>	12	21	22.30%
No response		6	6.38%
		94	100%

<i>Caring Ethos:</i>			
<i>Least cherished</i>	1	4	4.26%
	2	4	4.26%
	3	4	4.26%
	4	3	3.19%
	5	6	6.38%
	6	2	2.13%
	7	3	3.19%
	8	6	6.38%
	9	10	10.63%
	10	8	8.51%
	11	7	7.45%
<i>Most cherished</i>	12	29	30.85%
No response		8	8.51%
		94	100.00%

Circumstances are changing the face of medicine when one examines the objective conditions that doctors are faced with. South Africa has been subjected to huge stresses in its social fabric. This led to many analysts concluding that it is only now and in the near future that as a society we will have to come up with innovative answers to the problem brought about by a breakdown in the social fabric. A few years back the buzzword to describe the youth that appeared to have no direction in life was ‘the lost generation’. This description overlooked the factors that led to society producing this kind of young people. This phenomenon was not limited to the youth but also other aspects of society. The high crime and murder rates were publicised all over the world. The home security industry boomed in a short space of time as fear ran amok in almost every household. A number of those who had the financial means to escape the turmoil left for overseas destinations, leaving their country of birth due to what they perceived as the breakdown in social life. It seemed for a moment that the value for life was no more cherished in South Africa.

The country has for the past five years been counting its losses in the professional arena. Skilled and experienced people left the country for a number of reasons amongst them being the security situation but also more importantly the economic situation. In the mid-to late 1980’s many of South Africa’s young doctors left for Western and European countries to escape military conscription. This also had a financial aspect in that they could tap into better resourced health systems that needed their well groomed clinical

skills in exchange for a financial reward they could not get in their country of birth. The medical profession is a highly mobile profession, as the American Dr Anthony Dajer observed ¹⁵; ‘Medical personnel are easy migrants, for their skills find a ready market’. South Africa is not alone in the problem of loss of people with specialised skill. It is a worldwide phenomenon. Without the overt political reasons for trading their skills in overseas countries the debate has now openly been a financial one. It was interesting to find that the majority of respondents 25.54% ranked wealth as the least cherished value. Whether this was a true reflection or not, cannot be established from the survey responses. This should be taken into the context that there is tremendous pressure on doctors, especially in private medical practice to transform themselves into entrepreneurs or businesspeople.

The adherence to values such as honesty, caring, respect etc as a profession is significant because the professions play a crucial role in shaping our culture as a country. It leads the evidence when it comes to what can be considered scientifically helpful or harmful to humans. Doctors help shape the thoughts and understanding that influence the behaviour of human beings when they have to make choices about their lives where it matters most – life, disease and illness. Professions affect not only how individuals live and institutions work, but also the way we think about how we should live and about the ends that our social institutions should serve ¹¹. This in return places a burden on the professions to continually work towards and take responsibility for the common good as well as public interest.

Section 4: *Public Interest and Common Good:*

Public interest embodies a vision of a society that is made up of an alliance of self-interested individuals whose own good is made up of a complex of private interests. This represents an aggregation of the private interests of individuals who join together in an association dedicated to the pursuit of mutual advantage, with the following objectives ¹¹.

a) To maximise the collective realisation of individual interests

b) *To protect the integrity and functioning of those social arrangements, institutions and values that make peaceful, orderly life possible and mutually advantageous.*

In contrast to the notion of public interest, the notion of common good is associated with the vision of a society as a community, whose members are joined in shared pursuit of values and goals that they hold in common. Such a community comprises of individuals whose own good is inextricably bound up with the good of the whole. The medical profession serves to a great extent the personal needs, interests and good of individual patients in health. This is the basis for the most prized of all professional relationships, the doctor-patient relationship which has spread even to other professions like the attorney-client relationship that's viewed as sacrosanct in the courts of law. The medical profession fulfills this public service by making their knowledge and services available to the general public. A number of institutions through which the profession 'dedicates itself to the pursuit of matters of both common good and public interest' exist in our country in the form of Centres of Higher Learning. South African Medical Schools dedicate themselves to educating and training professionals who serve the public in a variety of capacities. Fulfilling the public duties – obligations and responsibilities owed in service to the public as a whole- is however governed by forces external to medicine namely: *government policies, economic and other social factors*. This is significant in the South African context because, as mentioned earlier, of the history of racial segregation that impacted heavily on all spheres of life including human resource training for the country.

Besides institutional structures Professional Associations or Interest Groups engage in the activities of common good and public interest on behalf of the professionals who are members. Despite the various forms through which they may exist, their nature and principles of existence are similar.

Section 5: *The Nature of Interest Group Politics:*

Like any other animal species on earth human beings have a tendency to group together around issues that are of common concern. The current trend in organising doctors is through the establishment of what is referred to as 'Interest Groups'. The membership of

these groups is very specific e.g. General Practitioners, Cardiologists, Surgeons and so on. The central theme is how to advance the group's collective interests in the face of competition from other groups or structures especially if this involves shared resources in a country. Even though these crafts or disciplines are organised into separate groups, they still have a broad overarching representation as a profession in the form of a national association. National associations like the British, Canadian, South African, American etc are organised in this fashion. These national associations are in turn influenced by the processes that exist within the national political framework in their respective countries. Structures like the National Council (S.A.), General Medical Council (British) and Delegates Convention (American) are effectively the medical professions' equivalent of a national parliament.

These organisations tend to be formulated along the structure of the decision-making processes that they seek to influence. For example, the decision-making processes of our government involve national and provincial structures at a central level and this has influenced many organisations to dedicate substantial resources to their national and provincial structures so that these can apply their attention and energies at these levels of governance. The aim of all Interest Groups or Organisations is to obtain favourable policy decisions through either exerting pressure or influencing the decision-makers within the parameters that they function in. They therefore concentrate on the activities and processes that government operates under. Activities of government also influence the Interest Groups in a major way through the manner in which they respond to attempts by organisations to influence or pressurise them to taking policy decisions that are favourable to particular organisations. For a long time, governments have played the game of setting one group against the other if they notice that there is no harmony within the same sector groupings.

The medical profession has for a considerable time considered the idea of employing people with a specific aim of lobbying parliamentarians in a bid to influence them towards deciding favourably on issues affecting the profession. The final analysis was that with the current government, this was not a wise approach. The big weapon that has been applied by the current government is its commitment to consultation and transparent governance

rendering lobbying a less effective strategy. The nature of consultation and transparency are relative terms that have to be taken in the context of the actual application of processes that relate to them.

It is vital for any organisation especially a professional association to carefully select their target for influencing. Professions are groups of intellectuals who are in command of specialised knowledge and therefore will tend to interact and target specialists in government structures. In our situation the reality is that these bureaucrats are no ordinary civil service employees but professionals in their own right who have a political mandate to fulfill. Their mandate encompasses the government's commitment to redressing the past apartheid imbalances in health care. The structures and activities of government influence the way in which organisations plan their programmes e.g. when certain health legislation is under debate in parliament, the medical association will plan activities that will draw attention to its desired policy outcomes.

Government structures influence the structural organisation of professional associations too. The government political organogram has national, provincial and local structures and most organisations have adopted similar formats. Even the naming of branches has followed suit by adopting names of provinces and so on. The South African Medical Association still lags behind on this in that there are still outdated branch names that are more in keeping with the past culture like 'Southern Transvaal, Highveld, Griqualand West' branches etc.

'Attitudes influence the scope and intensity of pressure group politics not only because they determine policy but also because pressure groups generally require some sort of legitimisation before they can come into play in the political process' ¹⁶. This is often the case with almost all the professional groupings when they exist in a society that is undergoing change. Change although influenced to some extent by professionals is geared towards the poor majority that delivers the vote at the polls. Unless the professionals and their associations can demonstrate their orientation towards community development, politicians are unlikely to take kindly to their advances. The medical profession has experienced this during Dr Nkosazana Zuma's tenure as Health Minister. The relationship

was almost non-existent and that severely compromised the ability of both the profession and health authorities to develop a common agenda for the reconstruction of health care services.

Section 6: *Mechanisms and Processes of interaction:*

A new phenomenon in our national politics is the commitment shown by government to the principles of transparency and consultation. This with time has reduced the level of resistance that authorities were faced with. When people that are aggrieved feel that they are listened to, even if the end product may not necessarily be what they initially desired, and feel that they are part of seeking the solutions, satisfaction sets in quickly. They even go to the extent of defending the decisions taken. Active commitment to these principles has served to rekindle the basic social values of respect of opposite views. These have found their way into the political and social life of South Africans.

Consultation and negotiations in our South African context are not buzzwords but concrete concepts that are religiously followed even in the private industry environment. Dismissal of employees without consulting their trade union is now almost a non-existent practice in the business world of South Africa.

Consultation is a process through which the government, institution or body with veto powers solicits views and opinions of those who have an interest in the matter at hand so that these can be taken into account but are not absolutely necessary for decision making. In contrast negotiation is a process where the decision hinges upon consensus being reached by all parties involved. None of the negotiating parties has any veto on the proceedings. Interesting arguments and philosophical debates about consultation have arisen in many instances. Some regard these as semantic debates, but the difference between ‘*in consultation with versus after consultation with*’ have held back a number of very important processes from being settled. The medical profession has found itself entangled in these debates many times in the last five years. My understanding of ‘*in consultation with*’ means that the main party will take a decision based on the consultative process involving the other party and the decision is made known and agreed to by the

counterpart. ‘*After consultation with*’ means that the main party takes the decision without necessarily soliciting agreement with the counterpart as long as the other party has been part of the discussions.

The negotiation process between medical associations that resulted in the formation of SAMA was at some stage delayed because of the differences in the interpretation of these concepts. On the national political level the government has created structures to deal directly with consultation processes that it has committed itself to. The Public Service Coordinating Bargaining Chamber (PSCBC) is an example of a structure where all salary and major general issues affecting the public service are negotiated with the state. Due to problems of dilution sector specific chambers were set up and these deal with all matters affecting only that particular sector e.g. health.

Section 7: *Operational mechanisms of professional associations:*

Interest groups like professional associations have a peculiar way of operating even though structurally there may be similarities with other organisations. They have governance structures resembling more or less the way government’s machinery is set up. SAMA has a National Council resembling the Parliament, a Board of Directors resembling the Cabinet, several Standing Committees of National Council resembling government departments and so on. Success of its operations is based on the following factors:

- a) *Possession of physical resources*
- b) *The size of the organisation*
- c) *The legitimacy of the organisation*
- d) *Organisational cohesiveness*
- e) *Political skills*
- f) *Maturity and integrity of the leadership*
- g) *Presence of technical expertise in its management*
- h) *Members in influential positions*
- i) *Effectiveness in its work*

j) *Influence over doctors*

k) *Ownership of a journal or other effective communication tool*

These factors are crucial for any medical professional association to succeed. The public, other professionals, government officials and the association's members themselves use these as barometers for the association. Other factors like the alignment of the association to societal priorities are complimentary yet very important and necessary for the survival of the organisation.

Section 8: *Trade Unionism versus Professionalism*

Debates about trade unionism versus professionalism have existed over many years. If doctors are considered as health 'workers' in the general understanding of the term worker, should they be treated any different from the way other workers are treated? Should their association base its activities on trade unionism or professionalism or both? In general doctors view themselves as professionals due to the fact that their craft displays the following characteristics ⁴:

- a) There is a *body of knowledge and skill* held as a common possession and extended by united effort. This implies that knowledge is peculiar to the group and research is a pre-requisite to the professional status as it is used to build up the knowledge.
- b) There is an *educational process* based on this body of knowledge for which the professional group as a whole has a recognised responsibility. This puts the responsibility of education in its hands and is achieved through various means e.g. setting of educational standards by the Medical and Dental Board's Education Subcommittee and the Colleges of Medicine, Continuing Professional Development conducted by peers. This ranges from the standard of entry to medical schools by candidates to the level of competence expected of doctors when they are working professionals.
- c) A *standard of qualification* for admission to the professional group based on character, training and proved competence. Post-graduate education and specialist practices are clear examples. The South African Medical Association exemplifies this through its

criteria for admission for membership and furthermore for its Specialist Groups. Qualification alone has for a long time been considered a prerequisite sufficient enough to qualify for membership of Specialist Societies, however the societies are now moving towards ensuring that its members keep themselves updated to maintain competence.

- d) *Standards of conduct on courtesy, honour and ethics* that guide the practitioner in his/her relationships with clients, colleagues and the public. The medical profession has a formal ethical code in the form of the Hippocratic Oath. This was written many centuries ago by Hippocrates a Greek physician born between 470 and 460 B. C. This document, a standard on qualification as a doctor at all medical schools, is interesting as it shows that even during his time doctors were already organised, with regulations for the training of disciples and with an ‘esprit de corps’ and a professional ideal. To date it is still referred to as an important statement of medical ethics. The following excerpts are central to the ethical nature of medicine ⁶:

I solemnly pledge myself to consecrate my life to the service of humanity.

I will give my teachers the respect and gratitude which is their due.

I will practice my profession with conscience and dignity.

The health of my patient will be my first consideration.

I will respect the secrets, which are confided in me even after the patient has died.

I will maintain by all means in my power, the honour and the noble traditions of the medical profession.

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life from the time of conception; even under threat I will not use my medical knowledge contrary to the laws of humanity

I make these promises solemnly, freely and upon my honour.

- e) A more or less *formal recognition of status* by colleagues and by the State as a basis for good standing. A lot of responsibility is attached to a doctor, not only by the patients, but also by colleagues. Colleagues expect you to be exemplary of the

profession, be competent and trustworthy. The State buys your services on behalf of its citizens and wishes to be assured that you are well qualified to take the responsibility of people's lives. For the State to purchase such services from the professionals, it must give recognition and thus legitimacy to the knowledge and skills possessed.

- f) The *organisation of the professional group* being devoted to its common advancement and its social duty rather than the maintenance of an economic policy. A professional association distinguishes itself by concentrating more on professional matters than trade union or economic activities. The production and development of knowledge is not directly related to the pursuit of an economic policy internally. However macro economic issues facing the country can severely affect this.
- g) The profession being *responsible for its own affairs and for its own standards*. Professionals influence many spheres of life and carry the pioneering responsibilities in social engineering. To guarantee success and acceptance in public, the profession must prove to society and to its international counterparts that it has internal regulatory processes that have integrity and can be trusted.

These ideals represent what the profession is pursuing but constrained by the changing social values and economic pressures. Several attempts have been made in many countries to examine what the core values of the medical profession are and what role the profession sees itself playing in society. This is of relevance to South Africa where the medical profession has played a particular role during the years of the repression of the majority of the people.

The concept of a medical association fulfilling a trade union function cannot be overlooked in the South African setting. The government's commitment to improving public health has led to drastic measures being taken to address problems of shortages in several areas including human resource. On a number of occasions doctors have found themselves experiencing labour related problems brought about by the state's desire to redistribute the human resource to areas of greater need. Among other problems are the financial constraints that have led to the freezing of posts in the public health sector. This means non-replacement of staff that has left, exerting a burden on the few who have to carry a bigger load. SAMA, as a trade union of doctors is constantly faced with problems

where young doctors are forced to work overtime that, according to the public service code, is voluntary. The irony is that in many instances young doctors get forced to perform overtime work by the medical superintendents who also happen to be members of SAMA.

The constitution of the Republic of South Africa protects the rights of individuals and gives them a number of freedoms. However these freedoms are sometimes in conflict with what patients and/or health authorities expect from doctors. Rather than mounting court challenges, the association opts for the route of challenging what is viewed as violations of its members' rights from a labour perspective. The case in point here are the issues of allocation of Community Service posts to young doctors and the overtime work problems. The allocation of posts for the community service are done by the Department of Health, using criteria that have been very difficult to challenge. The right of the individual to choose where to work is therefore compromised.

Chapter Four:

The medical profession and the Truth & Reconciliation Commission

Section 1: *The medical profession and human rights*

The role played by the health workers, in particular doctors came under close scrutiny of the Truth and Reconciliation Commission at its hearings held on June 18, 1996. The following section (7.1 – 7.5) taken from the T. R. C's report⁷ clearly illustrates the problems experienced by society when the medical profession neglects its responsibility of looking after the health of patients and discarding the profession's internationally recognised values.

1.1 Professional Health Organisations during apartheid years

In his testimony, Dr Barry Kistnasamy noted:

The social consequences of apartheid were so gross, so thoroughly destructive and so widely acknowledged and abhorred by the international community that there could be no avoiding the intrusion into the professional lives of the medical men and women of this country.

It was surely the task of the statutory and professional organisations to ensure that professionals were able to provide ethical and appropriate health care, regardless of the policies of the government in power. If, as Dr Kistnasamy states, those policies made this impossible, it was for the statutory and professional bodies to speak out against those policies.

1.2 The organised medical profession

History has shown that the two most powerful bodies with which doctors were associated - the SAMDC and the MASA - failed to speak out or take a stand for most of the period under review.

The SAMDC was a statutory body and, during the period under review, was responsible for the registration, education, maintenance and monitoring of professional standards of

conduct as well as for disciplinary enquiries into allegations of misconduct of all health professionals except nurses and pharmacists.

The successor body to the SAMDC, the Interim National Medical and Dental Council (INMDC), prepared a submission to the Commission on behalf of the earlier body. The submission made it clear that the SAMDC saw itself as an independent body:

Although created by statute originally in 1928, the SAMDC was not an organ of state. It was totally funded by the health care professionals falling within its jurisdiction. The majority of its membership was persons who were not appointed by the Minister.

Yet, the SAMDC was viewed widely as an almost parastatal organisation, lacking in independence. Nothing highlighted this more than its initial failure to launch an investigation into the conduct of the district surgeons, Drs Tucker and Lang, after the death of Steve Biko. The following explanation was given as to why the SAMDC's first enquiry into the matter in 1980 differed so markedly from the second enquiry in 1985 (undertaken in large part in response to continued public outcry):

When eventually (the second) inquiry was held, that was a completely different body in a different Council. Remember the Council's terms of office stretch in five-year terms, or used to. So, that was one Council from 1980 to 1985 and then a new Council from 1985 onwards. So that when eventually this inquiry reached the stage where it came before Council, there was a completely new Council with new members, and that Council then came to the conclusion that the practitioners were in fact guilty.

One might question this explanation. A body responsible for discipline and the maintenance of professional standards of conduct should display consistency in applying those standards.

The SAMDC, in contrast, displayed no hesitation in taking action against another of its members who was guilty - not of negligence in treating patients, but of resisting the apartheid regime. Dr Aubrey Mokoape was a doctor convicted of terrorism in 1974. During his interrogation, he was put into solitary confinement, beaten and tortured. The

Council did nothing to protest about this treatment and proceeded to use the criminal offence ('terrorism') as the basis for launching proceedings against him as a medical professional. It eventually dropped its charges against the doctor, but the case demonstrates that the SAMDC could take swift action when it deemed it appropriate.

Another significant problem raised in the hearings was the fact that the SAMDC was only able to respond to complaints or submissions made to it. This inability to be proactive severely hampered its capacity to monitor and maintain professional and ethical conduct.

In a letter submitted to the Commission after the hearing, Mr Nico Prinsloo, on behalf of the executive committee of the SAMDC, stated:

The Committee resolved that the [Truth and Reconciliation Commission] be informed ... that the Executive Committee wished to state explicitly that it records an apology in respect of any acts of omission or commission on the part of the SAMDC in not taking firmer steps to negate the effects of an unacceptable social system.

The apparent collusion of some doctors with state security forces and the lack of response from professional bodies in relation to this led to deep divisions within the South African medical world. Therefore, two bodies came to represent the medical profession - MASA and the National Medical and Dental Association (NAMDA).

The older body, MASA, was a voluntary, independent, professional association for medical doctors. It was historically (at the time of reporting) the largest professional medical organisation in South Africa, with a membership of about 14 000. At the time of the hearings, it saw its role as 'empower[ing] doctors to bring health to the nation' by representing the collective interests of the profession and the patients it serves, as well as shaping health policy to meet the needs of the community.

MASA made a 104-page submission, the result of an extensive study of its records and archives. The submission noted that MASA had members that actively supported the apartheid government and members that actively opposed it. Rather than focusing on the activities of individuals, the document examined MASA's role as an association. It said, in this regard:

The Association in general was quite comfortable with the status quo, and its public reaction to any criticism of the inequity and the iniquities in society, particularly the inequities in health care delivery, was to dismiss that criticism as the work of enemies of the state and it defined all sorts of means to defend itself and the system.

The submission also acknowledged the fact that MASA failed to respond appropriately to the health needs of the majority of South Africans.

MASA was always, without doubt, a part of the white establishment ... and for the most part and in most contexts, shared the worldview and political beliefs of that establishment. Inescapably, it also shared the misdeeds and the sins for which the white establishment was responsible.

Dr Hendrik Hanekom the Secretary-General of MASA clearly acknowledged the organisation's past positioning in his response to a question at the hearing:

MASA was so wrapped up in its white, male, elitist, educated, professional world as individuals and as a collective organisation and as part of a broader society from which doctors were drawn, that it failed to see the need to treat all people as equal human beings. Perhaps the same could be said of other groupings in society. MASA allowed black and white people to be treated differently, and this is the form of human rights violations for which it stands disgraced.

The written submission added, however, that the events surrounding the death of Steve Biko forced MASA to begin a long process of examining the ethics and morality of its actions.

This sad and disgraceful episode marked the beginning of a movement within the association, a movement of opposition to the actions and attitudes of the then leadership of the Association which, haltingly and with many setbacks and failures, finally grew powerful enough so that by 1989, it was quite clear that the Association had set its feet firmly on the road of renewal and transformation.

NAMDA was an 'alternative' medical association, formed on 5 December 1982. In its submission to the Commission, the Progressive Doctors' Group (PDG), a core group of ex-

NAMDA doctors formed to pursue discussions about a united medical association for South Africa, gave some of the reasons for the NAMDA breakaway from the MASA. These included:

- a) the conduct of the profession in respect of the medical conduct of those responsible for the death of Steve Biko;
- b) the devastating effects of apartheid on health and human rights, and
- c) the failure of existing medical organisations to respond cogently to these issues.

With the increased repression of the 1980s, it became important to work at making health facilities safe or providing alternative services. NAMDA, together with other professional organisations, such as the Organisation for Appropriate Social Services in South Africa (OASSSA), took on this responsibility.

NAMDA disbanded in the early 1990s when it became evident that South Africa was moving towards a new democratic dispensation in which the Department of Health would (it was believed) take on the issues that had triggered its creation.

The PDG highlighted a number of other concerns in its submission: The first was the harassment of NAMDA and its members, which manifested itself in various ways. Second, was the concern that so few health professionals came forward at the time to testify about human rights abuses in the profession: 'It seems that many more health professionals were aware of problems or were involved in problematic practices than they were prepared to acknowledge'. A third concern was the way in which certain research was conducted, particularly in the area of occupational health: for example, heat acclimatisation chambers set up to 'customise' workers to the work place. Last was the fact that, at the time when NAMDA was supporting the '*Free the Children*' campaign, MASA was involved in drawing up, '*Children in places of detention: a code for their handling*'. In other words, while NAMDA abhorred the very concept of detaining children, MASA was trying to find ways to make it more acceptable.

1.3 Lack of support from institutional bodies

Institutional bodies such as the Department of Health, the SAMDC and the MASA contributed indirectly to breaches of ethics by district surgeons. None of them took responsibility for the inadequacies of the system in which these doctors operated. The Department of Health was responsible for ensuring that district surgeons (who were, after all, employees of the Department of Health) were aware of their rights and responsibilities within the prison and police systems. It should have provided practical guidelines for action by district surgeons faced with situations in which violations of ethical conduct seemed inevitable. The SAMDC was supposedly responsible for dealing with those guilty of professional misconduct and for educational guidelines and ethics. There are well-documented cases in which the SAMDC failed to take proper action on professional misconduct. Both the SAMDC and the MASA gave little support to those who upheld human rights, thus discouraging health professionals from challenging the system. None of these organisations provided guidelines to assist district surgeons in dealing with adverse situations, in which it was almost impossible to treat detainees properly.

1.4 District Surgeons as a TRC case study:

The evidence available to the Commission suggests that most district surgeons were not directly involved in committing gross violations of human rights during the period under review. Their most common offence was a failure to carry out their duties within internationally accepted guidelines of medical ethics and human rights. All these points are starkly illustrated by the Steve Biko story. The doctors failed to:

- (a) maintain patient-doctor confidentiality norms;
- (b) treat their patient with dignity and respect;
- (c) examine the patient thoroughly;
- (d) record and report injuries accurately;
- (e) diagnose illnesses and prescribe appropriate medication;
- (f) register complaints (particularly pertaining to assault and torture).

On many occasions, district surgeons examined patients with security officers or prison warders in the room, which may have inhibited patients from disclosing abuse or torture by the police. This practice also reinforced the belief of prisoners that district surgeons collaborated with the authorities. District surgeons breached patient-doctor confidentiality by allowing third parties (police or prison authorities) automatic access to patients' files without informing the patients concerned or obtaining their consent. International standards require a doctor to inform the patient *before* he or she conducts an examination if the information in the medical records will be released. Finally, a number of deponents (generally detainees) told the Commission that they did not receive what they believed to be appropriate care from district surgeons.

These circumstances were aggravated by the fact that most district surgeons were white, while the majority of the detainees were black. Because white and black people had for years been separated by apartheid policies, there was a strained relationship and a lack of mutual trust and understanding between doctor and patient.

Many district surgeons also claimed that they did not know they could override the orders or wishes of prison warders or police on medical matters - for example, by not releasing information or by insisting that warders leave the room during examinations. Finally, where a district surgeon *did* take a stand to uphold the human rights of his or her patients, he or she received little or no official support from the profession or the Department of Health.

1.5 The TRC's verdict on the role of professional organisations:

Little evidence was found of the direct involvement of health professionals in gross violations of human rights. However, the health sector through apathy, acceptance of the *status quo* and acts of omission allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times, actively compromised. In this environment violations of moral and ethical codes of practice were frequent, facilitating violations of human rights.

The commission thus found that:

- a) Professional medical bodies and associated structures failed to fulfill their

professional duty and stated aim of protecting the health of patients, by neglecting to draw attention, amongst other things, to the effects of the socio-economic consequences of apartheid on the health of black South Africans.

- b) Solitary confinement is a form of torture, and detention had a severe impact on the health of children detainees. The medical profession failed to take a sufficiently robust stand against such practices.
- c) The statutory councils and professional bodies represented almost exclusively the white male mindset, thus ignoring the needs and interests of millions of South Africans. No attempt was made to address this problem and improve representivity.
- d) Statutory councils and professional bodies failed to conduct proper investigations into allegations of misconduct by doctors and nurses against political prisoners and detainees.
- e) Tertiary institutions responsible for the education of health professionals failed, without exception, to ensure that students engaged and internalised issues of ethics and human rights in health care.

Section 2: *The values survey*

A random sample was drawn up from a list of medical doctors who are registered with the Medical and Dental Board of the Health Professions Council of South Africa. The names were drafted so as to cover all the nine provinces and include rural towns. The survey was conducted in the period December 1998 to April 1999 by means of a questionnaire. There is currently no reliable statistical information as to the total number of doctors in South Africa and their racial breakdown (This is relevant due to the fact that for many decades training in medicine was biased towards advantaging the white population). The majority of doctors are white graduates from 5 traditionally white universities of Cape Town, Stellenbosch, Free State, Pretoria and Witwatersrand and it is estimated that they form 75% of the total number. The HPCSA has about 30 000 medical doctors in its register

with an estimated 5 500 based in overseas countries. An estimated 2 500 still maintain their registration with the HPCSA.

Determining the accurate racial breakdown of medical doctors is very difficult. My inquiry at my Alma Mata, University of Natal Medical School on the racial breakdown of its alumni since 1957 drew a blank, with a response that the school did not keep a register to that effect. This could have been influenced by the nature of information I requested i.e. the number and breakdown in terms of Indian, African and Coloured components. Admission for training at medical schools still remains a problem today, five years after the overthrow of apartheid. The number of black students at some medical schools has slightly increased¹³ but overall the situation is still not satisfactory e.g. the number of African students admitted to the University of Witwatersrand and University of Natal decreased between 1994 and 1998 as shown in figure 1. These historical facts are evident in the manner that the medical groupings view and respond to health transformation issues.

Section 3: *Admission for training in the health sciences*⁷

Opportunities for black South Africans to become health care professionals were extremely limited in the case of doctors and mental health professionals; although far less so for nurses. Before World War II, no black doctors were trained in South Africa. None of the medical schools in South Africa would admit black students and all black doctors received their training overseas. There does not appear to have been any statute preventing medical schools from accepting black students; it simply did not happen. Some of the schools claimed that it was because they did not have the facilities (such as separate residences) in which to accommodate black students.

The outbreak of World War II ended overseas training. From that time, a few black students were admitted to the University of Witwatersrand (Wits) and the University of Cape Town (UCT). However, very few black doctors were trained until 1951, when the University of Natal in Durban (UND) Medical School (in later years referred to as UNB denoting *Black Section*) was opened exclusively for black students. In 1959, the University Extension Act was passed, requiring black students to obtain ministerial

consent before they could attend a white university. This made it very difficult for black students to enter any medical school other than UND and, in turn, for many aspiring medical students living outside Natal (as it was then) to attend medical school. UND was far from their homes and many did not have the financial resources to pay accommodation and travel expenses and academic fees. A small number were, however, able to attend white universities if they could convince the Education Ministry that extenuating circumstances prevented them from attending UND. The number of black medical students increased from the early 1980s, after the Medical University of Southern Africa (MEDUNSA) was established. This was part of the apartheid plan to keep blacks (especially Africans) out of white universities, while at the same time ensuring a supply of black doctors to care for the black population. The lost opportunities that resulted from the University Extension Act are impossible to quantify, although one can say with certainty that numerous black people were kept out of the medical profession. Between 1968 and 1977, for example, 86 per cent of all newly qualified doctors were white, while white people comprised less than 20 per cent of the population. By contrast, 3 per cent of the new doctors were African, while Africans constituted 71 per cent of the population (see Figure 2).

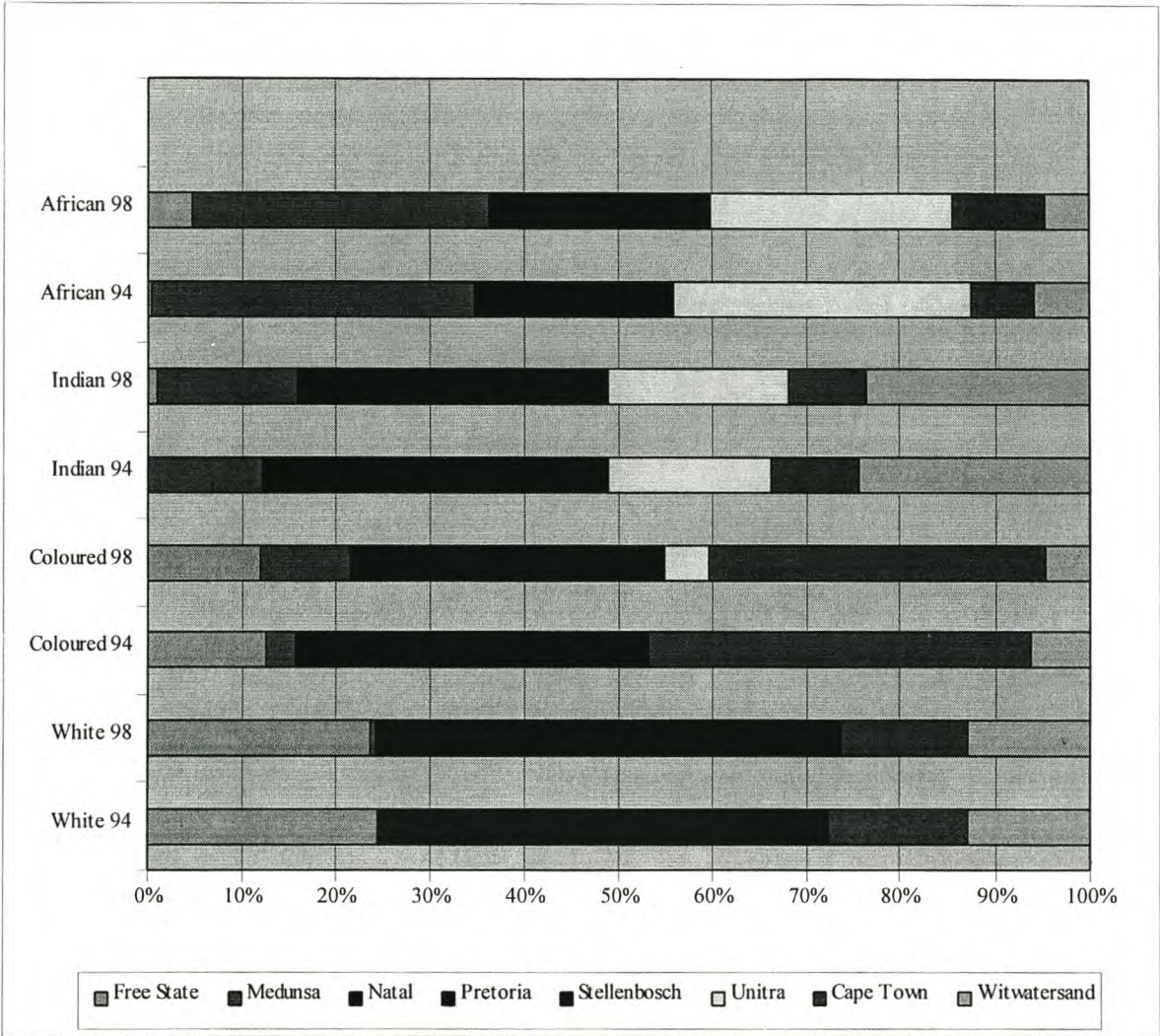


Figure 1: Changes in racial proportions at South Africa's 8 Medical Schools

Free State, Medunsa, Pretoria and Cape Town numbers are based on all medical students enrolled in 1994 and 1998.
Witwatersrand, Unutra, Stellenbosch and Natal numbers are based on first year entry in 1994 and 1998

Racial composition of doctors compared to the racial composition of the population

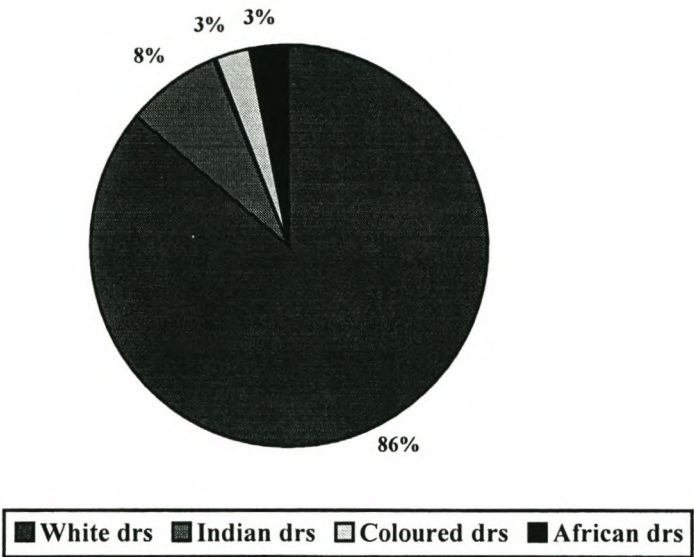


Figure 2: Mean percentage of doctors

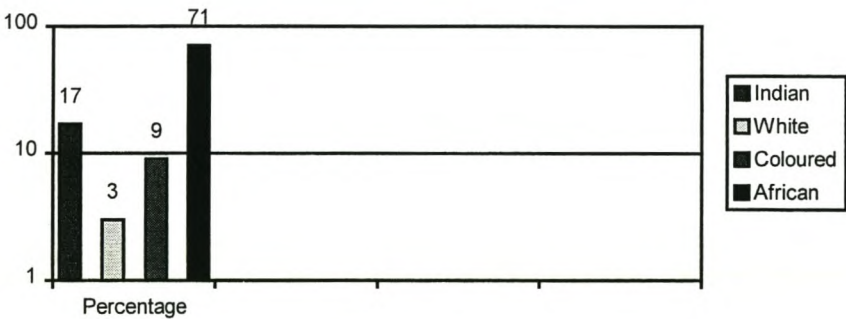


Figure 3: Mean percentage of total population

Note: Figures are the mean average percentages for 1968-1977.

Source: Data from the Health and Human Rights Project submission to the Truth Commission.

There are no reliable up-to-date figures available on the total number of doctors working in our health care system. This may improve with the implementation of the Health Professions Council’s new registration system. The following are the number of doctors working in the public health sector ¹⁴.

<i>Category</i>	<i>White</i>	<i>Indian</i>	<i>Coloured</i>	<i>African</i>	<i>Total</i>
Medical Officers	2958	1036	148	1601	5743
Registrars	1149	135	52	268	1932
Specialists	1394	266	54	218	1604
Total	5501	1437	254	2087	9279
Percentage of total	59.28	15.49	2.74	22.49	100%

Table 3: Number of doctors working in the public health sector

These figures need to be treated with caution as they include non-South African medical graduates. However it can be noted that even in 1999 ratios are still unacceptably skewed towards the white population as they were in the period 1968 to 1977. It is very difficult to get information about the actual number and breakdown of doctors working in the private health sector. Even the statistical information kept by the Board of Healthcare Funders is not reliable because it contains the number of practices and not individual doctors.

The assumption in my survey was based on this reality and therefore 75% of the questionnaires were sent to doctors with surnames that were assumed to be of white origin. The rest (25%) were sent to doctors whose surnames are African. A total of 300 questionnaires were sent by post and 94 responses were received. This represents a 31.3% overall response rate. Of the questionnaires sent to white doctors 66 (29.3%) were returned and of those sent to black doctors 26 (34.7%). The questions covering a broad range of issues were designed to give an indication as to the geographical location, mode of practice, experience as signified by the years since qualifying from Medical School, practice population, gender, age group and language of communication with patients.

Responses by geography, mode of practice and practice arrangement:

Province	Private	Public & Private	Public	Total	Solo	Partnership
KwaZulu-Natal	10	2	1	13	8	5
Eastern Cape	4	4	0	8	5	3
Western Cape	21	10	0	31	13	15
Northern Cape	1	3	0	4	1	3
North West	4	1	0	5	4	1
Northern Province	1	2	0	3	3	0
Gauteng	7	1	0	8	6	2
Mpumalanga	4	1	0	5	3	2
Free State	10	3	0	13	10	3

Table 4: Total responses by province

A total of seven respondents either failed to indicate in which province they are, mode or nature of their practices.

Gender	Number	Percentage
Female	16	17.02
Male	76	80.85
No indication	2	2.13
	94	100

Table 5: Responses by gender:

A total of 69 gave an indication of how many years ago they qualified from Medical School giving an average of 18.09 years. The range was between 3 years and 51 years. Seventeen (17) respondents were in the range 1 to 10 years, 26 respondents in the 11 to 20 years, 15 respondents in the 21 to 30 years and 11 respondents in the 31 and above range.

Chapter Five:

Transformation challenges and the medical profession

Section 1: *The South African organised medical profession in perspective*

Medicine developed from the early years of its existence as an exclusive craft, practised by those who were privileged. The art / skill was taught within Guilds which were organised groups of medical men who possessed, shared the knowledge and skills of practising medicine. They also furthered their interests by developing internal rules effectively controlling who could join or be taught the skill. This resulted over many years in medicine being shrouded in mystery. Even the Hippocratic Oath urges the young graduate to only teach the skill to the sons of his teachers and of his own thus excluding those who happen to be out of this circle.

Some attempts at developing an organisation of doctors started in South Africa in the 1800's but with very little success. Doctors during those times were trained in Britain and consequently became members of the British Medical Association (BMA) through its South African branches. In 1883 the attempt to form the South African Medical Association intensified accompanied by a call to start a South African medical journal in 1886. Interestingly the call for a journal succeeded while the formation of an association independent of the BMA was put on the back burner. This was however renewed in October 1892 at an exhibition of the of the first South African Medical Congress held in Kimberly where Dr Arthur Fuller pressed for the formation of the South Africa Medical Association and the publication of the journal ¹⁷. At a South African Congress held in Durban in 1895, Dr W. T. F. Davies appealed for unity in the profession by declaring: '*What we medical men need is combination – Trades Unionism – call it what you will. We want to combine together to decide on our duty to each other, our duty to the public and public's duty to us, and see that these duties are properly performed*'. The first congress of the association was subsequently held in Johannesburg during September of 1898. By this early stage the association already had the experience of what still exists in the profession today, apathy. It is reported that doctors in the Transkei area did not even bother to return the ballot papers for the election of the first council of SAMA. In 1927 the

association decided to terminate its affiliation to the BMA and reconstitute itself as the Medical Association of South Africa (MASA).

With the advent of apartheid, medical politics changed face over a period of time. The culmination was the death in detention of Steve Biko in 1977. The failure of the South African Medical and Dental Council to take disciplinary action against the two medical practitioners involved in providing an unprofessional service to Mr Biko hours before his death changed the history of medical politics in South Africa. MASA dragged its feet on the issue leading to some prominent members to resign from its Federal Council. MASA and thus the medical profession's leadership had failed to protect a culture of human rights and protection of human life. A walkout by the black doctors was inevitable and in 1982 the National Medical and Dental Association (NAMDA) was launched following an intensive two year preparatory process. From the onset, NAMDA pledged itself to bringing about and upholding a human rights culture in medicine / health and tirelessly work for the attainment of a better health care system for all South Africans. Huge amounts of resources went into developing policy papers; community based projects involving NAMDA members and political activities that the members idealised.

The security and political machinery of the State developed as much interest in this phenomenon as MASA did. Some prominent leaders of this section of the medical profession were harassed, detained and houses bombed in a bid to discourage the conscientious medical doctors from identifying with the struggles of the poor against apartheid. On the other hand MASA remained entrenched in the apartheid philosophies and through its members unwittingly helped advise the government on apartheid policies in health. The cleavage in medical professional circles followed the trend in the country with white doctors largely supporting apartheid policies and black doctors largely supportive and active in attempts to remove apartheid. Provision of health services by doctors also followed the same pattern. Even to date black doctors are more successful in providing services to black patients than they could be practising in majority white populated areas. Of the 26 black respondents in my survey almost all have an average percentage African patient population of not less than 90%.

Section 2: *The need for the medical profession to transform itself*

Many leaders from within organised medicine have shared the idea of uniting the profession but the hindrance has always been the deep-seated suspicions and undeclared agendas from various elements within. It was not until 1996 that discussions about the unification of medical associations took a meaningful turn. The basis for this process was that South Africa and its people are in need of a united medical profession that will play a meaningful role in health care matters. The first step was adoption of a resolution: 'Declaration of Commitment' followed by a policy document titled: 'The Ideal Medical Professional Association'. The Ideal Medical Professional Association document acknowledges the following in its analysis of the current situation ¹⁸.

'The division in the ranks of the medical profession leave the profession vulnerable to exploitation and manipulation which, if not addressed, will be to the detriment of the health of the nation – from the delivery of quality health care to the upholding of the ethos of medicine. In addition it should be recognised that the medical profession is a conglomerate of diversified groups, whose interests frequently conflict with regard to issues pertaining to health and practice of medicine. These differences have nothing to do with political ideologies and will continue to exist beyond the transformation process (of the associations).'

This serves as an admission by the profession itself that there were numerous challenges to overcome before the profession could even consider what role and how to fulfill it in transforming our country. This policy document sought to bring together the different value systems that its components are derived from. The main purpose of the new association was seen as being to empower the medical profession to bring health to the nation and the following, among others, was identified as the role that it has to play:

- a) To promote the integrity and image of the medical profession by examining:
 - i. The (profession's) role and (its) values in a changed society
 - ii. Behavioural, ethical, clinical and educational standards
 - iii. Self-regulation

- iv. Democracy and human rights
- b) To develop medical leadership and skills in the following areas:
 - i. Organisational, political and community level
 - ii. Black, female and young doctors
- c) To provide doctors with knowledge relevant to the demands of practice and socio-political developments in the health care environment
- d) To encourage involvement in health promotion and education concentrating on:
 - i. Community upliftment projects
 - ii. Reconstruction and Development Programme -directed projects

The governance structures were envisaged to display the following characteristics:

- a) *Be credible and reliable in the eyes of the public*
- b) *Provide a forum for discussion and debate on key health policy issues*
- c) *Serve as a mechanism to solve disagreements within organised medicine*
- d) *Promote trust within the profession*
- e) *Commit itself to democracy, upholding and protection of human rights*

This served as a basis for the establishment of the new South African Medical Association espousing the traditional values of medicine and committing itself to playing a role in the transformation of our society. However, the age-old challenges are still prevalent to this day and are no different to those experienced by the profession's leadership more than 100 years ago. The terms such as apathy, aloofness, selfishness and others are commonly used by some members of the public in characterising the conduct of the medical profession. As a result some doctors cite these as major impediments to achieving total unity and thus affect transformation of medical politics.

The black doctor segment seems to be suffering from these problems the most. This may be unfair criticism as they form the minority of the medical profession but it is on the other hand expected of them to be advocates and champions of the aspirations of the black communities. These communities have for a long time been excluded in the mainstream development of the human resource in medicine. Transforming the medical political scene

has its roots in making sure that black doctors are part and parcel of the leadership bringing in the diversity needed to take this country forward. With far less or even non-existent risks associated with medical political involvement than during the apartheid days, it is a reasonable expectation that they come forward to provide the leadership for change. Participation during the apartheid era was hindered by a number of possible factors, leading to them remaining noncommittal. These factors could have been:

- a) An element of risk involved when an individual associated himself / herself with activities that could be viewed as being against the state. This usually translated to imprisonment or even death.*
- b) Sheer apathy – symbolised by the lack of interest in any activity outside one's preferred personal interests.*
- c) Different understanding of what roles the medical professionals have in society.*

Meanwhile there exists an expectation from the black communities that professionals will lead the way for them out of the legacy of apartheid. These range from matters within the confines of medicine, like the provision of quality health services to the influence of medical education and training. For many years, only one medical school, the University of Natal Medical School popularly referred to as University of Natal - Black Section (UNB) trained black doctors of any significant number. Being admitted to the medical school was no guarantee that one would ultimately qualify as a doctor. A policy of exclusion on grounds of “poor academic performance” was strictly applied and was a source of anxiety for especially the African students who were affected by Bantu Education policies. As chairman of the Medical Students Representative Council (MSRC) I spent a lot of time with my colleagues fighting for the abolition of this policy. This had profound effects on the production of doctors to serve the poor communities who are invariably black. As medical students we saw as part of our role in society the defense of those who had the capability to become doctors but were negatively affected by racially designed policies to keep the number of black medical graduates low. The irony is that some of those students declared academically unfit to become medical doctors went on to study medicine in other universities and countries, notably the Medical University of Southern Africa (MEDUNSA) and some are now leading figures in the field of medicine.

This is still an arena for the profession to take responsibility for and create mechanisms to address the severe shortage of doctors in and from the black communities. The question of whether medical educators are aware of the needs of the society in terms of the provision of a human resource element of health care comes up. The single most important demand in health care is provision of such services to poor rural communities many of whom have no services of a doctor. Should the black doctors, the majority of whom have previously been subjected to harsh conditions not be the ones who spearhead a campaign to improve the situation on behalf of their communities? Influencing national policies or local university policies could be just the best advocacy role they can play.

There is an assumption about the medical profession that it is a profession that has members driven by beneficence, high conscience and values commensurate with the status accorded to the profession by society. Medical doctors are therefore expected to be driven by values and obey rules higher than those of civil society. What this assumption overlooks is the fact that doctors are derived from within the ranks of society in different communities and therefore are products of normal families who have peculiar characteristics. Like any individuals they have dreams, aspirations, influences and preferences to contend with. They are not driven by uniform personal goals in life. The goals and traditions of the medical profession are what they can comfortably commit themselves to as a collective. Their individual reasons to study medicine are also varied ranging from influence, the desire to serve the community, an interest in medical interventions to a desire to live a comfortable life offered by the perceived economic security. For some doctors born and raised in poverty stricken families there could be an element of escaping the poverty cycle and in the process help the community. On the other hand for some it could be the continuation of a family tradition whereby medicine becomes a career of choice within the family.

These varied backgrounds are what form the microelements of the medical profession in that it is these experiences, expectations and value systems that get carried to the development of what each doctor views as his/her responsibility to society. It may therefore be a mistake to expect medical doctors to be equally responsive to social stimuli.

The challenge currently is to what extent they can be responsive to internal problems. From the existence of only one organisation, MASA, a string of organisations was formed since the 1977 Steve Biko incident. Most have been spurred not only by politics but largely by the changing economic situation prompting the question of self-interest versus altruism of the medical profession. Concentration on economic factors has led to a number of unprofessional activities and the resultant disciplinary steps against some doctors by the Professional Board.

Section 3: *The challenge of human resource distribution*

Private medical practice has flourished in our country in the past two decades resulting in the emasculation of the public health sector that is losing experts of many years experience to an unregulated private sector. This sector is driven and sustained by those who have the ability to pay and is thus largely inaccessible to the majority of South Africans. This becomes a dilemma for the whole profession due to the prevailing practices designed to maximise profits. Invariably the doctor's commitment is foremost to consider that the patient's interest does not become compromised. The stigma of doctors chasing profits has unfortunately developed and got stuck to private medical practitioners. It is not uncommon to hear comments that private doctors are making millions of rands in a depressed overpopulated market - a contradiction indeed.

Economic means of survival have a major influence in the life of a doctor. Like any other profession, medicine should provide some rewards for people to enter the profession in the first place. Those rewards include the financial security within reasonable limits enabling the doctor to lead a comfortable lifestyle comparable to professionals at a similar level in society. Economics has become a focus in medicine. The public health sector is known not to be very competitive when it comes to the level of salaries paid to doctors. Despite the difficulties there are still a large number of doctors who have committed themselves to serving the public within this sector. They serve the public under the most trying conditions, being expected to practically carry out the state's policies on health reform and explain to near dying patients why they cannot receive treatment or be operated on. This is one of the most difficult responsibilities that a doctor can have. The public sector doctors

have to care for the poorest in society yet little recognition or acknowledgement is given to these foot soldiers. On the other end of the spectrum the health reforms have unearthed interesting debates. One of the proposed legislative reforms is the granting of licences by the Department of Health to private general practitioners to dispense medicines. This policy has not only evoked anger within the affected section of the profession but also reignited a century old debate between doctors and pharmacists about who is really qualified to dispense medicines. The SAMJ 1983 Special Issue¹⁷ notes that the Medicine and Pharmacy Amendment Bill of August 1899 was passed amid great controversy and opposition by medical practitioners.

It quotes Dr Darley Hartley as saying: 'Counter prescribing by chemists is a growing evil, dangerous to the public and most unfair to ourselves'. But he further suggested compromises that interestingly enough, are what is proposed in the legislation today. He wanted to see prescribing by the chemist restricted but, as a fair quid pro quo, added: 'we might submit to an enactment forbidding the issue of a compounding license to any medical practitioner resident in a town in which a registered chemist is in business' ¹⁷. This is exactly what has prompted the South African General Practitioners to be up in arms against this proposed legislation. Many doctors resent any attempts by government to regulate their practices. The new South Africa Medical and Medical Devices Regulatory Act (SAMMDRA) has met with fierce resistance especially in its proposals to regulate the dispensing of medicines. When, in 1980 the government of Nicaragua proposed a bill to regulate medical practice, it met fierce opposition from the medical establishment that claimed that the government was interfering in their professional affairs ¹⁵. Similar arguments have also been advanced by the medical profession in South Africa.

Their argument is that the general practitioner gives an excellent service to the poor patients by discounting their prices in what is termed a package deal. This is a one-price charge designed to include both consultation fee and the cost of medicines dispensed in one price. The argument goes further to suggest that the doctor will then make up for these generous discounts through those who are insured by the Medical Aid Schemes. What is inexplicable is how this is done if all patients are treated equally and receive the same medicines for the same illnesses. The truth is that those who get the packaged deal price

provided with very cheap (but effective) medicines ensuring that the doctor still gets a profit on dispensed medicine. The consultation fee is therefore discounted. Those covered by Medical Aid are often the biggest victims in that they are given medicines that will definitely work, but the doctor claims from the Medical Aid for medicines much more expensive than what was prescribed. If this is not the case, then the whole package deal concept defies all logic associated with a market economy. This is the biggest dilemma for independently practising doctors in terms of the medicines regulatory framework proposed for legislation. A number of practitioners have been exposed as being fraudulent in their activities, further denting the image of the profession. General Practice suffers the most from this legacy.

General Practitioners are the point of first contact that patients have with the health care system in many areas where doctors are available. It is my contention that the South African Medicines and Medical Devices Regulatory Act is the biggest test yet to face the medical profession's primary health care physicians in terms of dispensing regulations. If they embrace the changes, they stand to benefit from new opportunities that may result. However it will take hard bargaining because it is the government's intention to re-distribute human resource through licensing. Those who do not get awarded licences will be compelled to either set up rural practices or join the public health sector. It is highly impossible that the public sector can afford to employ all doctors in the public sector.

Opposition to this dispensing legislation can be attributed to the following factors:

- a) *The extreme obsession with economic success and profit accumulation*
- b) *The individualistic and highly competitive nature of general practice*

The serious political divisions, which existed in the broader medical profession in previous years, have now been replaced by economic interest differences that the doctor groups have. This is most peculiar to general practice and seems to run along racial lines resembling the racial past. Examples of this are:

- a) The National General Practitioner Group comprised of white GP's,

- b) The Family Practitioners Association and the Society of Dispensing Family Practitioners comprised of Indian doctors,
- c) The Dispensing Family Practitioners Association comprised of Coloured and Indian doctors and
- d) Association of the South African Medical and Dental Practitioners comprised of African doctors.

The majority of these groups have commercial entities that have tended to take a similar structural formation too. This is a tendency that will take years to break, as doctors tend to rely on their own people for support through patronage. This affects the thinking and expression of values that individual doctors adhere to as it forms the base for the doctor-patient relationship central to the profession's traditional value system.

For a profession to even start debating what role it has to play in our transforming society, it has to heal itself first. The South African medical profession has come a long way towards realising that dream. The launch of the South African Medical Association (SAMA) in 1998 was the first of the many steps necessary in a chain of processes to providing the profession with an avenue to participate in reconstructing our country. The second step is for the profession through its representative association to align itself with the new ethos of society. A number of professions within health care that were considered lesser ones have now gained status and enjoy recognition within health care teams thus putting a strain on the doctors who for many years enjoyed running the show without being questioned. Doctors now have to be team members and not necessarily instructors and have no option but to adapt. Their recognition is however not in danger nor are their knowledge and skills under question. Their role, crucial to health care delivery, can be enhanced because:

- a) *As a profession, they possess knowledge and skills that are needed by society*
- b) *They have the practical experience of running the health care system and can therefore help adapt it to the needs of our people*
- c) *As intellectuals their analytical skills and international networks with other colleagues can be effectively used to improve our system*

All this must be done in an atmosphere that is conducive to change and transparency.

Section 4: *Relationship between the profession and health authorities*

What relationship should exist between the medical profession and the health authorities? The short answer is one that is cordial and complementary. However we have a history characterised by a high degree of differences, suspicion, hate, exploitation and extreme measures of control. It is therefore no surprise that the past five years of democratic governance have seen no major 'toenadering' (coming closer) between the profession and the Department of Health as an arm of government. The government's commitment to health reform concentrating on primary health care, providing better access to care facilities for the poor communities meant a shift of resources (mainly financial) from tertiary health care facilities to the underprivileged areas. This adversely affected tertiary care institutions where the medical profession happens to be well entrenched. The cry about the eminent demise of high quality academic medicine will be on the national agenda for a long time to come.

There is great need for the medical profession to develop and nurture a constructive relationship with health authorities and should be based on the following:

- a) Development of a common vision*
- b) Development of trust and acknowledgement of points of difference*
- c) Proper management of areas of conflict*

4a. *Development of a common vision:*

The medical profession is a community on its own with traditions, goals and values that are peculiar to it. It has the ability to generate and develop its own knowledge and processes that ensure its sustainability. However, the financial resource it needs to further these aims is largely provided by the State. This means that the public representatives become the custodians of funding for medical education and training including research

that gets huge grants from the government like the Medical Research Council. However, the needs of the profession are not necessarily the same as those of the ordinary people. Creative tension therefore exists between the public representatives and the representatives of the profession in relation to the allocation and distribution of the limited financial resources to health priorities. In most instances these priorities differ markedly.

The emphasis on the curative health services in the past benefited the profession more than the recipients of health care. Material for research was abundant and the lack of a human rights culture in health care made it possible for this to flourish as many patients were used as research objects under the pretext of curing their illnesses. Medical knowledge and expertise grew tremendously as more and more resources were pumped into non-preventative services. The reforms brought about by the 1994 change of government shifted the emphasis to preventive health promoting primary health care services. With dwindling financial resources there had to be a shift from highly specialised tertiary to primary health care. The medical profession has been very lukewarm in its embracing of these changes. The medical schools have been at the forefront of the 'cries of foul' due to the financial constraints placed on them by the funding squeeze.

There is therefore a noticeable gap between the government (health authorities) and the profession in terms of what the future should look like. The gap lies in the absence of a common vision that identifies the issues that need to be attended to secure the future. The government faces an enormous task of improving the lives of and health of people who previously had no access to basic health care. In addition the Ministry of Health has to compete for these resources with other Ministries equally challenged by legacies of apartheid. It has to look at what areas it can sacrifice certain services in order to provide in other areas. This is done under the influence of political considerations. The medical profession, divided in individual member priorities as it may be, has a different challenge to that of government. Reduction in funding of tertiary health care institutions means an inability to progress in the research capability, a difficulty in employing and retaining specialists in the public health sector and ultimately a compromise in the training of young doctors for the future.

It is necessary that both parties systematically work together to develop a common vision for health care in all aspects.

4b. *Development of trust and acknowledgement of differences:*

The formation of SAMA was met with caution from many quarters. The involvement of the Progressive Doctors Group (a remnant of NAMDA activists) created a little discomfort with some organisations wary of this group of well-known medical ANC activists trying to unite the medical associations. These happened to be former arch-rivals of MASA and suspicions could not be avoided. Despite of this trust soon developed when colleagues started working together in committees of the association. The trust between the profession and health authorities must be worked at and will quickly develop if there is openness on both sides to involve each other in working committees that the Department of Health sets up from time to time. It must also be acknowledged that there will be areas of differences and that when this happens it will in no way hinder the progress of pursuing the common vision. It calls for the intense scrutiny of relations, removing as much as possible any political clouding of issues. Developing trust at senior leadership level is paramount. This will help unlock resources of various forms for the benefit of health care in our country.

The profession has an untapped potential in the form of doctors who reside and/or work in underprivileged communities. The services they offer are directed towards individuals or family units based on illness and intervention decisions taken by the doctor. The bigger concept of doing service for the community as a collective is still foreign to the majority of doctors. It is only the young post internship doctors who are obliged to do community service within the precincts of rural hospitals mostly. The absence of the bigger concept can possibly be traced to the kind of undergraduate tuition the doctors received. It was geared towards serving individualistic needs and not the collective needs. The HIV/AIDS epidemic has exposed the shallowness of community skills that doctors possess. The doctors' approach to HIV has been limited mostly to clinical interventions. Seldom do doctors participate in community based initiatives to combat the spread of the disease yet they could be an asset to the communities, based on the expert knowledge and ability to

analyse situations. Participation in community activities will certainly re-introduce the role modeling that doctors used to fulfill in years gone by. The spin-off for the medical profession will be an improved image and trust by the community. Public health promotion / education is one area that should be an ethical obligation for doctors to fulfill.

4c. Proper management of conflicts:

South Africans have almost perfected two areas in social engineering;

- a) The ability to create resentment and fight one another*
- b) The ability to overcome obstacles and create peace against all odds*

In a nation scarred by social turmoil it is not unreasonable to expect major conflicts whilst we are still in search of a common goal. Conflicts when properly managed bring about dignity even to the warring parties. The interdependence between the health authority and the medical profession is unavoidable and so is the history associated with it. However, public fights do not necessarily bring about victories even if one party has massive public support. The recent 1999 strikes by the public sector unions are an example. Despite the massive public support they received, the government was not moved in its resolve to contain the salary increase to public employees.

The presence or even the nature of conflicts or differences is not as important as how they are managed and resolved. They must be managed very professionally so as to preserve the credibility of participants and the integrity of our health system. The advantage in health is that the medical profession through its public promise, the Hippocratic Oath, became conditioned to not embarking on certain actions as they view them as putting patients' lives at risk. The cordial relations currently existing between SAMA and the Department of Health make it possible for the profession to be a major player in the shaping of health policy.

Section 5: *Community involvement, role modeling and mentorship:
Public duties of South African medical professionals?*

Role modeling has been a value synonymous to the medical profession for many years. A significant number of doctors were influenced in many ways by their predecessors in the way in which they carried themselves in public and their dedication to serving their communities. Medicine has always been a value-laden profession but the structure of medical practice nowadays makes it a bit difficult to explicitly express these values. Some critics put the blame on the undergraduate medical education and training for producing individualistic graduates with habits that are difficult to change or eradicate. The concept of the profession involving itself in health promotion activities is very rarely discussed or even practised.

The most commonly advanced reason is that health promotion tends to empower the recipients with medical knowledge thus diluting the mystical nature of medicine. Participation of doctors in community activities should be done proactively by the profession on a collective basis. Although a number of doctors participate on an individual basis the majority do not and it is the actions or non-actions of the majority that get easily noticed by the public. As a general practitioner in the impoverished township of Khayelitsha in Cape Town for about seven years, I quickly discovered that the expectations of the community served by my surgery went beyond my skills and knowledge of medicine. I was often approached to provide emergency services at soccer matches (which meant going home late on a Saturday), performing or supervising circumcisions in the bush huts, address youth gatherings on selected health topics, advise learners on career choices and identification of possible sources of funding. Nothing gave me more joy than the parents who would come to me to express their appreciation for the example they felt I was to their children. Many doctors do this kind of work daily in their surgeries but it seems to go unnoticed when taken in the context of the profession's role in this transforming society.

One loyal patient brought this point home clearly when she rebuked the profession for its obsession with economic matters above their responsibility to care for patients and be

good role models for the young. She alleged that we have lost our values and are now more concerned with making profits out of ill health than responding to our calling as expected. If this assessment can be regarded as having even a shred of truth in it, the medical profession then has an enormous task to rebuild its image. The best way for us in South Africa is to develop a strong representative South African Medical Association that is responsive to the needs of society. A transforming society is one that is on an unstable journey, learning new ways of securing a better future for its future generations, discarding what seems not to work and modifying / adapting what appears to have a potential to work in the future. All professions and professionals are crucial to this stage of growth because they are an intellectual resource that the society has invested in. The situation may demand that they play slightly modified roles from what they are accustomed to.

The profession has a role in transforming South Africa. It has a wealth of values traditionally held within its ranks and appreciated by society. The route to enhancing its influence in society is the collective participation in public health matters. This will provide the medical profession with an opportunity to influence national events and developments and ultimately improve the image and earn the respect it desperately needs. Health promotion is an untapped area. The World Medical Association (WMA) ²⁰ at its 47th General Assembly held in Bali, Indonesia in September 1995 adopted a resolution on health promotion emphasising the central role that medical practitioners should play in the health care system of a country. The resolution states that:

- a) *Medical practitioners and their professional associations have an ethical duty and professional responsibility to act in the best interest of their patients at all times and to integrate this responsibility with a broader concern for and involvement in promoting and assuring the health of the public.*
- b) *Public health agencies benefit greatly from close cooperation with and support by medical practitioners and their professional associations. The health of a community or a nation is measured by the health of all persons in that community or nation, and the preventable health or medical problems that affect an individual person have an impact on the health of the community and its resources. The effectiveness of many*

programmes to enhance the health of the public, therefore, is dependent on the active involvement of medical practitioners and their professional associations in concert with public health agencies.

- c) Examples of the types of activities that are effectively conducted collaboratively between the private and public health sectors are: public information and education programmes to promote healthful lifestyles and reduce preventable risks to health, including those from: use of tobacco, alcohol and other drugs; sexual activities that increase the risk of HIV transmission and sexually transmitted diseases; poor diet and physical inactivity; and inadequate childhood immunisation levels.*
- d) Other types of activities, such as disease surveillance, investigation, and control are primarily the formal responsibility of public health agencies. These public health activities cannot be conducted effectively, however, without the active cooperation and support of the medical practitioners at community level who are cognisant of personal and community illness patterns and who notify health authorities promptly of problems that might require further investigation and action.*

The WMA adopts resolutions like these for the purpose of providing guidance for National Medical Associations as they consider the appropriate role in their jurisdiction for medical practitioners and professional organisations to be involved in public health responsibilities and advocacy for health promotion. The views expressed in this resolution are further strengthened by an earlier resolution adopted at the 40th WMA Assembly in Vienna, Austria in September 1988 on Access to Health Care²⁰. It declares on the issue of public education that *'educational programs that assist people in making informed choices about their personal health and about the appropriate use of both self-care and professional care should be established. These programs should include information about the costs and benefits associated with alternative courses of treatment; the use of professional services that permit early detection and treatment, or the prevention, of illnesses; personal responsibilities in preventing illnesses and the effective use of the health care system. In local communities it is important that the public understand health care plans designed for their benefit and how these plans affect everyone concerned. Physicians have an obligation to actively participate in such educational efforts'*.

Section 6: *The role of the medical profession: respondents' views*

The world community of medical practitioners therefore identifies public participation of doctors as being crucial for the success of the health systems of their countries. The survey conducted for the purposes of this thesis evoked varied responses to a question posed on what role each respondent thought the profession has in a transforming South African society. A few regarded this as a blatant political question to which they chose to not respond as they believe that medicine must be kept out of politics.

The majority was however very keen to answer and responses were varied as follows:

a) There must be one culture between the profession and the government:

This refers to the development of a common vision and commitment to high standards of health care delivery specifically in the public sector. The profession and health authorities must be seen to be partners in the development of the health system and always display sensitivity about the needs of the communities.

b) The profession must contribute towards transformation in our country.

The medical profession has a number of resources that can be put at the disposal of our country ranging from material to human resources. The intellectual capital the profession possesses is not limited to medicine but can be utilised in other areas e.g. providing leadership from community to national level.

c) We must practicalise the Alma-Ata declaration ¹⁹ in South African terms.

This declaration strongly affirms that health (which is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity) is a fundamental right and the attainment of the highest possible level of health is the most important world-wide social goal, whose realisation requires the action of many other social and economic sectors, in addition to the health sector. This burden lies on not only the health sector, but the medical profession must take a leadership role in correctly interpreting the declaration.

d) We must teach the medical undergraduates principles of Ubuntu.

Ubuntu (humanity) is a basic African concept that requires people to subscribe to the principles of compassion, honesty, respect, kindness, care and so on. It requires

of one to always be an example of what is good about being human. These concepts are fundamental to the practice of medicine and must therefore be emphasised in the training of future doctors.

e) We must make available private practices as some form of resource to the public health sector.

There are General Practitioners in almost every town or district of South Africa. Some of these are well resourced with essential equipment like Ultrasound scanners, Radiographic machines and other medical machinery. Specialist practices are even much more equipped than surgeries of general Practitioners. These also tend to be partnership practices. Development of a private/public partnership health system could make available these resources for the public health system through some arrangement for reimbursement.

f) There must be voluntary community service by the profession.

Community service should be limited to young graduates only. It must extend to the whole profession and be elevated to high status for those who participate. This could vary according to the needs of a particular community. A doctor could work in a local clinic for at least 3 hours a week as a contribution to the community he/she serves without expecting remuneration. Well managed, this could be a big contribution by the profession to uplifting public health service delivery in this country.

g) The profession must support the spirit of legislative processes and eradication of poverty.

As identified by the Alma Ata Declaration, health goes beyond the absence of disease or illness. Health is a socio-political matter. Those who suffer most are the poor with little or no access and virtually non-existent influence on the political decision-makers. South Africa has a government that declared health as one of its priorities and it is upon the medical profession support legislative processes aimed at reforming health and those directed at eradicating social causes of ill health.

h) The profession must join the fight against fraud and corruption.

Fraud and corruption are the scourge of modern society and health care has not escaped this. Fraud has been reported in health care especially involving the theft

of medicines and some doctors claiming fees for services not rendered. It is the duty of the profession to eliminate corruption from its ranks.

i) Medical professionals must protect the human rights of people.

This is a challenge emanating from the days of apartheid rule. It is the duty of each professional to uphold and nurture a culture of human rights and protect his/her patients against any abuse of such rights. This includes each citizen's right of access to equitable and decent health care, the right to be part of the decision making about his/her illness and the right to medical information relevant to his/her illness or disease.

j) There must be open interaction with other professions.

The medical profession is well known for its lack of interest in other professions and its non-interest in working with teams involving other professions in health care. The mindset has shifted to a team approach in the delivery of health care services. The medical profession has an immense role to play in such teams without necessarily being in a leadership position.

k) The profession must re-evaluate training needs and monitor the transformation of Medical Schools.

Questions are currently being asked about the appropriateness of medical training in South Africa, both at under- and post-graduate level. The national Department of Health has set up a task team to examine this issue with the aim of re-orientation of training if necessary. This team involves the Health Professions Council of South Africa and the profession must participate in all its various formations. There is a clear perception that even if the number of black students at Medical Schools is showing a slight increase, there is still a gross disparity between the number of black and white graduates in medicine. A number of doctors attribute this to a lack of visible transformation at the medical schools. It is the responsibility of the profession to monitor this process.

l) We must change the attitude towards each other as doctors and display a caring attitude towards patients.

A good spirit of collegiality must exist if the profession is to succeed in caring for the nation.

m) The profession must oversee the judicious allocation and utilisation of resources.

The profession has a responsibility together with government to ensure provision of equitable health services to the country's people. This starts with the allocation and ultimately the appropriate utilisation of health care resources. As it stands now, the medical profession by far presides over the utilisation of resources in hospitals, medical schools, medical research institutions and so on.

n) The medical profession must participate in the re-kindling of moral values.

Medicine is a profession laden with values and morality. It therefore must join hands with other initiatives to propagate good values in society. As part of the intellectual resource of South Africa, it must examine what role values play in a society like ours.

The wide-ranging nature of these suggestions is indicative of the eagerness of doctors to be part and parcel of the developments in our society. Maybe a system where doctors will through participation in community projects and health promotion activities, be allocated a number of stars by the Community Health Forums will encourage them. The Community Health Forums should consist of representatives from the community, the health service providers and department of health. These stars can then be taken into consideration, in addition to the normal health service impact assessment methods, when the doctors license to practice in that area comes up for review. The impact of health service providers is normally measured by the health indicators over a period of time e.g. the effect on reducing prevalence of preventable diseases and attainment of high immunisation levels in children.

Conclusion:

The speed at which South African society is transforming is unprecedented. The resultant forces and demands are based on the new needs of society that has been permeated by a number of influences. Consultation, negotiation, responsibility, accountability and so on are concepts that have been taken to great limits at community level. This has in many instances led to unwarranted feelings of entitlement. The positive aspect is that this phenomenon has led to a spread of knowledge among the ordinary citizens. This in turn helps to keep politicians in check, prompts professionals to learn and know what their responsibilities are and examine what their role in the transformation process of our country is.

The medical profession in particular is in the spotlight brought about by the intensive restructuring processes in health care. Provision of quality services, access to health care and equitable allocation and utilisation of resources are challenges that require the profession to play a central role in health care reform. The old inexcusable opinion held by some colleagues that medicine must be kept out of politics is very naïve. Health as part of the social issues consuming all governments is a political issue. However party politics should not affect the doctor's commitment to his/her patient's interests. This has a particular significance in South African history, as health was also used as a political tool to deny the majority a basic human right. It is the medical profession itself that has to define exactly what role it wishes to play in transforming the country. As a profession with values, traditions and goals, it must revisit these so that its foundation can be re-established by confronting its past, analyse the present and forecast the future.

This study reveals that there is still a significant number body of medical professionals who believe in the traditional values of medicine. They feel that doctors must play a meaningful role in the transformation and further democratisation of our country. It seems that the most appropriate route to go is:

- a) *The medical profession through its professional association creating a role for itself in public health activities e.g. health promotion education initiatives at grassroots level*

- b) *The medical profession and the Department of Health developing a common vision for the future of health care in South Africa*
- c) *The medical profession playing a leading role in the re-kindling of moral values and be an advocate for these in society.*

The establishment of the Ethics Institute of South Africa (EISA) in which the medical profession through the South African Medical Association plays a vital role, is a development designed to be a resource through which an ethical environment can be re-vitalised in our country. It is through institutions like this that the profession can find ways of interacting with other professions, share their knowledge and design mechanisms of participation and intervention, making available to society an accessible intellectual resource to deal with ethical challenges facing us.

However, ‘it is crucial that the public role of the medical profession does not conflict with the primary responsibility of physicians to their individual patients’ (*Marcia Angell in the article Medicine: The Endangered Patient-Centered Ethic*)¹¹.

APPENDIX 1: 'THE HIPPOCRATIC AOTH' (original version)

I swear by Apollo the physician, by Aesculapius, Hygeia and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and judgement the following Oath:

'To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgement and never to do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not be spread abroad, I will keep secret and will never reveal. If I keep this Oath faithfully, may I enjoy my life and practise my art, respected by all men and at all times; but if I swerve from it or violate it, may the reverse be my lot'

Appendix 2: The Values Survey Questionnaire

Practice Profile:

Q.1 In which province are you working?

Eastern Cape	
Free State	
Gauteng	
Kwa-Zulu Natal	
Mpumalanga	
Northern Cape	
North Province	
North West Province	
Western Cape	

Q.2 Are you working in:

Public Hospital?		
Private?		Please answer question 5 below
Private and Public Hospital?		Please answer question 5 below

Q.3 How long have been working here?

Q.4 When did you qualify from Medical School?

Q.5 Are you in solo or partnership practice? If in partnership, how many partners?

Yes solo ☐

Yes partnership

<input type="checkbox"/>	No. of partners:
--------------------------	------------------

Q.6 If in private where is your practice located?

City centre. ☐

Suburb. ☐

Township. ☐

Rural town. ☐

Rural settlement. ☐

Q.7 What percentage of your practice population would you estimate is made up of the following race groups?

African. ☐

White. ☐

Coloured. ☐

Indian. ☐

- Q.8** What fraction of the total patient population is covered by some kind of insurance (medical aid)?

Personal profile.

1. Of the following age groups, which one do you fall in (tick appropriate square):

20 – 29 years	→	<input type="checkbox"/>
30 – 39 years	→	<input type="checkbox"/>
40 – 49 years	→	<input type="checkbox"/>
50 – 59 years	→	<input type="checkbox"/>
60 years and above.	→	<input type="checkbox"/>

2. What is your gender:

Female ☐ or Male ☐

3. What is your first language?

4. In what language do you communicate with your patients?

(a) Do you have to make use of an interpreter? Yes / No

5. What are your opinions of the health department's commitment to transformation of health care and the provision of primary health care services?

Approve / Disapprove / Does not concern me.

6. Did the introduction / provision of free services to children under six years and pregnant women have any effect on your practice?

Yes / No

7. If yes, in what way did this affect your practice?

8. Are you aware of the following reform policies? If so, what is your opinion of each?

- 8.1 District Health System – a system where health delivery is delegated to local authorities to decide how best it can be done? Yes / No

Opinion:

- 8.2 Licensing of medical practices for dispensing of medicines – a system whereby all doctors dispensing medicines will be required to obtain a license to carry out this activity? Yes / No

Opinion:

- 8.3 Accreditation – a system where a provider of health services of any kind will have to satisfy certain minimum criteria to be allowed to engage in a particular form of health service provision? Yes / No

Opinion:

- 8.4 Re-certification of doctors – this is a new system that will require a doctor to obtain a minimum of 250 points over a 5-year period for him / her to be certified fit to practice medicine? Yes / No

Opinion:

- 8.5 Generic substitution of medicines – a policy aimed at reducing the prices of medicines by prescribing generic medicines instead of brand products where possible? Yes / No

Opinion:

- 8.6 Changes to the Medical Schemes Act – the amendment of this Act bringing in a range of changes to the way Medical Schemes will conduct their business in future? Yes / No

Opinion:

- 8.7 Managed Health Care – mechanism of controlling costs of health care by applying principles that influence both behaviour of patient and doctor?

Yes / No

Opinion:

- 8.8 Change of the Medicines Control Council to S. A. Medicines and Medical Devices Regulatory Authority – a body that will in future regulate registration of medicines, medical devices and conduct inspection of premises that manufacture or trade in any of these products? Yes / No

Opinion:

- 9 Are you aware that young doctors are henceforth required to do community service immediately after internship?

Yes / No

- 10 What is your opinion about this matter?

Strongly agree / Agree / Neutral / Disagree / Strongly disagree.

Further comments?

- 11 Do you know about Continuous Professional Development for doctors as proposed by the Health Professions Council of South Africa?

Yes / No

12 What is your opinion about it?

Agree / Do not agree / Indifferent about it.

13 Are you aware that it is seriously being considered to shorten the medical curriculum from six to five years plus 2 years of internship/vocational training?

Yes/No

14 What is your opinion about such an initiative?

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

15 Of the following values, cherished by the medical profession, which ones do you identify most with? Kindly rank them in order of your preference. (1 = least cherished up to 12 = most cherished)

- | | | |
|--|---|---|
| <input type="checkbox"/> Respect by the community. | <input type="checkbox"/> Recognition by peers. | <input type="checkbox"/> Honesty. |
| <input type="checkbox"/> Wealth. | <input type="checkbox"/> Privacy. | <input type="checkbox"/> Clinical Independence. |
| <input type="checkbox"/> Success. | <input type="checkbox"/> Scientific excellence. | <input type="checkbox"/> Professionalism. |
| <input type="checkbox"/> Integrity. | <input type="checkbox"/> Credibility. | <input type="checkbox"/> Caring ethos. |

16 In 1994 a new government was democratically elected and it soon embarked on the path of transforming society. What role should the medical profession play in the transformation process and how?

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